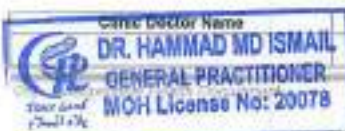




## MEDICAL EVALUATION REPORT FOR OQ CONTRACTORS - SUMMARY

| CANDIDATE / EMPLOYEE IDENTIFICATION      |                                                                                                                                                                                                                                                                                                       |                 |          |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------|
| Civil ID / Passport #                    | Company ID #                                                                                                                                                                                                                                                                                          | Name            | Position |
| 94201678                                 | 1440                                                                                                                                                                                                                                                                                                  | BALWINDER SINGH | RIGGER   |
| Nationality                              | Age                                                                                                                                                                                                                                                                                                   | Sex             | Company  |
| INDIAN                                   | 36 Yr M                                                                                                                                                                                                                                                                                               |                 | TON      |
|                                          |                                                                                                                                                                                                                                                                                                       |                 | Location |
|                                          |                                                                                                                                                                                                                                                                                                       |                 | HAMA     |
| EXAMINATION TYPE                         |                                                                                                                                                                                                                                                                                                       |                 |          |
| Examination                              | <input type="checkbox"/> Pre-employment <input checked="" type="checkbox"/> Periodic <input type="checkbox"/> Exit                                                                                                                                                                                    |                 |          |
| VITAL SIGNS & BODY MEASURES              |                                                                                                                                                                                                                                                                                                       |                 |          |
| Blood Pressure Category                  | 130/80 <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Prehypertension <input type="checkbox"/> Hypertension Stage 1 <input type="checkbox"/> Hypertension Stage 2 <input type="checkbox"/> Hypertension Crisis                                                                   |                 |          |
| BMI Category                             | 27.11 <input type="checkbox"/> Underweight <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Overweight <input type="checkbox"/> Obese <input type="checkbox"/> Morbid Obesity                                                                                                      |                 |          |
| Remarks:                                 |                                                                                                                                                                                                                                                                                                       |                 |          |
| VISUAL TEST                              |                                                                                                                                                                                                                                                                                                       |                 |          |
| Visual Acuity Test                       | RT 6/6 LT 6/6 <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                      |                 |          |
| Visual Field Test                        | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| Colour Vision Test                       | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| Stereoscopic Vision Test                 | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                                               |                 |          |
| Pre-existing condition:                  |                                                                                                                                                                                                                                                                                                       |                 |          |
| Remarks:                                 |                                                                                                                                                                                                                                                                                                       |                 |          |
| RESPIRATORY SYSTEM                       |                                                                                                                                                                                                                                                                                                       |                 |          |
| Spirometry Test                          | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| Chest X-Ray                              | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| Physical Assessment                      | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                                                                                                                                                                                                          |                 |          |
| Pre-existing condition:                  |                                                                                                                                                                                                                                                                                                       |                 |          |
| Remarks:                                 |                                                                                                                                                                                                                                                                                                       |                 |          |
| ENT SYSTEM                               |                                                                                                                                                                                                                                                                                                       |                 |          |
| Audiometry Test                          | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| Otscopy                                  | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| Physical Assessment                      | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Whisper, Weber & Rinne Tests)                                                                                                                                                                                           |                 |          |
| Pre-existing condition:                  |                                                                                                                                                                                                                                                                                                       |                 |          |
| Remarks:                                 |                                                                                                                                                                                                                                                                                                       |                 |          |
| CARDIOVASCULAR SYSTEM                    |                                                                                                                                                                                                                                                                                                       |                 |          |
| ECG Test                                 | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| Physical Assessment                      | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                                                                                                                                                                                                          |                 |          |
| Pre-existing condition:                  |                                                                                                                                                                                                                                                                                                       |                 |          |
| Remarks:                                 |                                                                                                                                                                                                                                                                                                       |                 |          |
| NEUROLOGICAL SYSTEM                      |                                                                                                                                                                                                                                                                                                       |                 |          |
| Physical Assessment                      | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                                                                                                                                                                                                          |                 |          |
| Pre-existing condition:                  |                                                                                                                                                                                                                                                                                                       |                 |          |
| Remarks:                                 |                                                                                                                                                                                                                                                                                                       |                 |          |
| MUSCULOSKELETAL SYSTEM                   |                                                                                                                                                                                                                                                                                                       |                 |          |
| Physical Assess                          | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                                                                                                                                                                                                          |                 |          |
| Lumbar X-Ray                             | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input checked="" type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| Pre-existing condition:                  |                                                                                                                                                                                                                                                                                                       |                 |          |
| Remarks:                                 |                                                                                                                                                                                                                                                                                                       |                 |          |
| LABORATORY INVESTIGATIONS                |                                                                                                                                                                                                                                                                                                       |                 |          |
| Lab Tests:                               | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal if abnormal, please specify below:                                                                                                                                                                                       |                 |          |
| Blood Grouping                           | O+ve                                                                                                                                                                                                                                                                                                  |                 |          |
| Pre-existing condition:                  |                                                                                                                                                                                                                                                                                                       |                 |          |
| Remarks:                                 |                                                                                                                                                                                                                                                                                                       |                 |          |
| Glucose Level Category                   | 98 mg/dl <input checked="" type="checkbox"/> Normal 80 - 100 mg/dl <input type="checkbox"/> Pre-diabetic 100 - 125 mg/dl <input type="checkbox"/> Diabetic > 125 mg/dl                                                                                                                                |                 |          |
| Cholesterol Risk Category                | 102 mg/dl <input checked="" type="checkbox"/> Low Risk LDL is less 130 mg/dl <input type="checkbox"/> Moderate Risk LDL 130-159 mg/dl <input type="checkbox"/> High Risk LDL > 160 mg/dl                                                                                                              |                 |          |
| Routine Urine Analysis                   | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| Stool Analysis                           | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input checked="" type="checkbox"/> Not Required                                                                                                                                                                                    |                 |          |
| QUESTIONNAIRES                           |                                                                                                                                                                                                                                                                                                       |                 |          |
| Medical & Surgical History Questionnaire | Remarks                                                                                                                                                                                                                                                                                               |                 |          |
| Respiratory Protection Questionnaire     | Remarks                                                                                                                                                                                                                                                                                               |                 |          |
| Hearing Conservation Questionnaire       | Remarks                                                                                                                                                                                                                                                                                               |                 |          |
| Screening Questionnaire                  | Remarks                                                                                                                                                                                                                                                                                               |                 |          |
| Fagerstrom Test - Smoking                | <input type="checkbox"/> Non-smoker <input type="checkbox"/> Low dependence <input type="checkbox"/> Low to Mod dependence <input type="checkbox"/> Moderate dependence <input type="checkbox"/> High dependence                                                                                      |                 |          |
| CAGE Questionnaire Alcohol Use           | <input type="checkbox"/> No use of alcohol <input type="checkbox"/> Screening negative <input type="checkbox"/> Clinically significant                                                                                                                                                                |                 |          |
| SRQ-20 Self-reported Questionnaire       | <input type="checkbox"/> No positive answers <input type="checkbox"/> Positive answers Factor I (1 to 5) <input type="checkbox"/> Positive answers Factor II (7 to 12) <input type="checkbox"/> Positive answers Factor III (13 to 16) <input type="checkbox"/> Positive answers Factor IV (17 to 20) |                 |          |



Doctor Signature &amp; Clinic Stamp

Issue Date

11.8.2025

Form-Rev-01-2020/2021

# FITNESS TO WORK CERTIFICATE - OQ CONTRACTORS



| EMPLOYEE IDENTIFICATION |              |                       |                                                                                   |          |  |
|-------------------------|--------------|-----------------------|-----------------------------------------------------------------------------------|----------|--|
| Civil ID / Passport #   | Company ID # | Matr. No: 26531       | Reg. Dt: 10/08/2022                                                               | Position |  |
| 94201678                | 1440         | Name: BALWINDER SINGH |                                                                                   | RIGGER   |  |
| Nationality             | Age          | Gender: Male          | Nationality: INDIA                                                                | Location |  |
|                         |              | Age: 36Y              | Mar. Status: Married                                                              | HAIMA    |  |
| Address:                |              |                       |  |          |  |

| EXAMINATION TYPE                                          |                                                                        |                                                          |
|-----------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Pre-employment Examination (PRE) | <input checked="" type="checkbox"/> Periodic Medical Examination (PME) | <input type="checkbox"/> Post-absence Examination        |
| <input type="checkbox"/> Change of Position Examination   | <input type="checkbox"/> Exit Examination                              | <input type="checkbox"/> Critical Activities Examination |
| <input type="checkbox"/> Emergency Response Team          | <input type="checkbox"/> Travelling Examination                        | <input type="checkbox"/> Medical Surveillance            |

| Medical Suitability for Work |                                                                                                                                                                                                     |
|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Medical Suitability for Work | <input checked="" type="checkbox"/> Fit to work<br><input type="checkbox"/> Fit with following restrictions<br><input type="checkbox"/> Pending Fitness<br><input type="checkbox"/> Not fit to work |

**FIT**

## Restrictions

|                                                          |                                                                       |
|----------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Working at height               | <input type="checkbox"/> Pulling, pushing or carrying weight          |
| <input type="checkbox"/> Working in confined space       | <input type="checkbox"/> Ascend/descend ladders and stairs            |
| <input type="checkbox"/> Working with electricity        | <input type="checkbox"/> Walking or standing for long distance/period |
| <input type="checkbox"/> Working near rotating machinery | <input type="checkbox"/> Repetitive movements                         |
| <input type="checkbox"/> Working in noise area           | <input type="checkbox"/> Mobile machinery operation                   |
| <input type="checkbox"/> Working in extreme heat         | <input type="checkbox"/> Heavy lifting operation                      |
| <input type="checkbox"/> Handling chemical products      | <input type="checkbox"/> Driving vehicle                              |
| <input type="checkbox"/> Use of respirator               | <input type="checkbox"/> Emergency response duty                      |

Other, specify

| New Position | New Function | New Department |
|--------------|--------------|----------------|
| NA           | NA           | NA             |

| Examination Date | Exams Performed |
|------------------|-----------------|
| 10/08/2022       |                 |

| Medical Review Date | Employee Signature                                                                   |
|---------------------|--------------------------------------------------------------------------------------|
|                     |  |

| Doctor Name          | Medical License | Medical Doctor Signature                                                             |
|----------------------|-----------------|--------------------------------------------------------------------------------------|
| DR. HAMMAD MD ISMAIL |                 |  |

DR. HAMMAD MD ISMAIL  
GENERAL PRACTITIONER  
MOH License No: 20078



# MEDICAL & SURGICAL HISTORY QUESTIONNAIRE



| CANDIDATE / EMPLOYEE IDENTIFICATION |  |                     |  |                    |  |
|-------------------------------------|--|---------------------|--|--------------------|--|
| Civil ID / Passport #               |  | Company ID #        |  | Position           |  |
| 94201678                            |  | 1440                |  | RIGGER             |  |
| Nationality                         |  | Age                 |  | Location           |  |
|                                     |  | 35                  |  | HAIMA              |  |
| Patient: 26631                      |  | Reg. Dt: 10/08/2025 |  |                    |  |
| Name: BALWINDER SINGH               |  | Gender: Male        |  | Nationality: INDIA |  |
| Mar. Status: Married                |  | Address:            |  |                    |  |
|                                     |  |                     |  |                    |  |

| PERSONAL HEALTH HISTORY                                                        |                              |                                        |                                                                                  |                              |                                        |
|--------------------------------------------------------------------------------|------------------------------|----------------------------------------|----------------------------------------------------------------------------------|------------------------------|----------------------------------------|
| Have you ever, or do you currently suffer from any of the following?           |                              |                                        |                                                                                  |                              |                                        |
| Congenital heart disease or Valvular heart disease or Coronary artery disease  | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Muscle problems e.g. weakness of your limbs or twitchy muscles                   | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Myocardial insufficiency or infarction (heart attack)                          | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Joint problems, e.g. plantar warts, joint pain or swelling                       | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Coronary bypass surgery (CABB) and angioplasty                                 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Problems with limb, neck or spine mobility                                       | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Heart arrhythmias (heart beats too fast, too slow or irregularly)              | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Extremities (feet or hands) deformities or problems                              | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| High blood pressure (hypertension)                                             | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Experienced back problem, arthritis, slipped disc                                | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Shortness of breath after exertion                                             | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Pain in neck or back or hands or legs                                            | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Varicose veins associated with varicose eczema, ulcers or other complications  | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Thyroid disease any other glandular diseases                                     | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Arteriosclerotic or other vascular disease                                     | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Diabetes mellitus or Hypoglycemia                                                | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Anemias, especially Sickle Cell Disease or Sickle Cell Trait or Thalassemia    | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Experienced weight loss or gain > 5kg over the past year                         | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Haemorrhage disorders i.e. bleeding disorders                                  | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Informed about being overweight or obese                                         | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Leukaemia, polycythaemia and disorders of the reticulo-endothelial system      | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Skin disorders e.g. severe acne, dermatitis, eczema or allergy                   | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| G6PD (Glucose 6-Phosphate Dehydrogenase) Deficiency                            | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Allergies e.g. dust, medication, insect bites                                    | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Recurrent headaches or migraine                                                | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Disorders of the digestive tract e.g. ulcers, recurrent diarrhea, gastritis      | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Epilepsy and recurrent seizures                                                | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Hemorrhoids, fistulae and fissures causing pain, or recurrent bleeding           | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Blackouts, dizziness, fainting, memory loss, unconsciousness (vertigo/syncope) | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Liver and pancreas diseases (e.g. pancreatitis, Hepatitis B)                     | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Sleep disorders, such as insomnia, hypersomnia, sleep apnea, narcolepsy        | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Kidney or bladder diseases e.g. recurrent infection, renal stones                | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Chronic anxiety states and/or recurrent depression                             | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Ear, nose or throat problems (e.g. otitis, hearing loss, sinusitis, tonsillitis) | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Phobias such as fear of heights, fear of confined spaces, fear of flying       | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Eye disease or visual defect (e.g. glaucoma, color blindness, monocular vision)  | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Lung disease e.g. bronchitis, asthma, dyspnea, TB                              | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Treated for infectious diseases (e.g. malaria, COVID-19)                         | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Phlegm production (excess mucus production) or tight chest                     | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Treated for depression, stress                                                   | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Immuno suppression due to cancer or human immunodeficiency virus               | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | Treated for substance or alcohol abuse                                           | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |

| List any previous injuries or operations |      |  |
|------------------------------------------|------|--|
| Previous injuries or operations          | Date |  |
|                                          |      |  |
|                                          |      |  |
|                                          |      |  |

|                                             |                                         |                                        |
|---------------------------------------------|-----------------------------------------|----------------------------------------|
| Have you visited a doctor in the last year? | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No |
| Are you taking any medication at present?   | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No |
| Are you pregnant?                           | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No |
| Date: 10/08/2025                            | Candidate/Employee Signature: Balwinder |                                        |



# SCREENING QUESTIONNAIRE



| CANDIDATE / EMPLOYEE IDENTIFICATION |              |                                                                                |                                                                                                           |
|-------------------------------------|--------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Civil ID / Passport #               | Company ID # | Client: 26631<br>Name: BALWINDER SINGH<br>Gender: Male<br>Age: 36Y<br>Address: | Reg. Dt: 10/08/2022<br>Position: RIGGER<br>Nationality: INDIA<br>Mar. Status: Married<br>Location: HALIMA |
| Nationality                         | Age          | Sex                                                                            |                                                                                                           |

| FAGERSTROM TEST                                                                                            |                                  |                                                   |                                      |                                      |
|------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------|--------------------------------------|--------------------------------------|
| Do you smoke?                                                                                              | <input type="checkbox"/> Yes     | <input checked="" type="checkbox"/> No            | If YES, Please answer the following: |                                      |
| How soon after waking up do you smoke your first cigarette?                                                | <input type="checkbox"/> >60min  | <input type="checkbox"/> 31-60min                 | <input type="checkbox"/> 6-30min     | <input type="checkbox"/> < 5 minutes |
| Do you find it difficult to avoid smoking where is forbidden, such as work places, cinemas, shopping etc.? | <input type="checkbox"/> Yes     | <input type="checkbox"/> No                       |                                      |                                      |
| What's the most difficult cigarette to quit or not to smoke                                                | <input type="checkbox"/> Anytime | <input type="checkbox"/> The first in the morning |                                      |                                      |
| How many cigarettes do you smoke per day                                                                   | <input type="checkbox"/> <10     | <input type="checkbox"/> 11-20                    | <input type="checkbox"/> 21-30       | <input type="checkbox"/> >31         |
| Do you smoke more frequently the first hours of the day than the rest of the day                           | <input type="checkbox"/> Yes     | <input type="checkbox"/> No                       |                                      |                                      |
| Do you smoke even when you're sick and have to stay in the bed most part of the day                        | <input type="checkbox"/> Yes     | <input type="checkbox"/> No                       |                                      |                                      |

| CAGE QUESTIONNAIRE                                                                           |                              |                                        |                                      |
|----------------------------------------------------------------------------------------------|------------------------------|----------------------------------------|--------------------------------------|
| Do you drink alcohol?                                                                        | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | If YES, Please answer the following: |
| Did you ever feel that you should decrease the amount of drinks or cut down (stop) drinking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |                                      |
| Do people bother you because they criticize the way you drink?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |                                      |
| Do you feel guilty or upset with yourself with the way you use to drink                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |                                      |
| Do you drink in the morning to feel less nervous or decrease the hang over                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |                                      |
| Have you had any problems related to alcohol                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |                                      |
| Did you drink in the last 24 hours                                                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No            |                                      |

| FATIGUE QUESTIONNAIRE                                                                 |                                 |                                        |                                      |                                    |
|---------------------------------------------------------------------------------------|---------------------------------|----------------------------------------|--------------------------------------|------------------------------------|
| Have you noticed that you are feeling tired recently                                  | <input type="checkbox"/> Yes    | <input checked="" type="checkbox"/> No |                                      |                                    |
| Have you been feeling a lack of energy                                                | <input type="checkbox"/> Yes    | <input checked="" type="checkbox"/> No | If YES, Please answer the following: |                                    |
| For how many days did you feel tired or with lack of energy in the last week          | <input type="checkbox"/> 1 day  | <input type="checkbox"/> 2 days        | <input type="checkbox"/> 3 days      | <input type="checkbox"/> > 3 days  |
| Did you feel tired or with lack of energy for more than 3 hrs in some days last week? | <input type="checkbox"/> 1 hour | <input type="checkbox"/> 2 hours       | <input type="checkbox"/> 3 hours     | <input type="checkbox"/> > 3 hours |
| Did you feel so tired that you had to make some effort to do things last week         | <input type="checkbox"/> Yes    | <input type="checkbox"/> No            |                                      |                                    |
| Did you feel tired or with lack of energy doing things you like last week             | <input type="checkbox"/> Yes    | <input type="checkbox"/> No            |                                      |                                    |

| SELF-REPORTING QUESTIONNAIRE (SRQ-20)           |                              |                                        |                                                              |                              |                                        |
|-------------------------------------------------|------------------------------|----------------------------------------|--------------------------------------------------------------|------------------------------|----------------------------------------|
| 1. Do you have trouble thinking clearly?        | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 11. Is your digestion not good?                              | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 2. Do you find it hard to like your daily work? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 12. Do you have unpleasant sensations in your stomach?       | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 3. Do you find difficult taking decisions?      | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 13. Do you get scared easily?                                | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 4. Is your daily work a suffering?              | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 14. Do you feel nervous, tense or worried?                   | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 5. Do you feel tired all the time?              | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 15. Do you feel unhappy?                                     | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 6. Are you easily tired?                        | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 16. Do you cry more than usual?                              | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 7. Do you have frequent headaches?              | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 17. Does the thought of ending your life occur on your mind? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 8. Do you feel lack of hunger?                  | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 18. Do you find it difficult to perform your work?           | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 9. Do you sleep badly?                          | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 19. Have you lost interest in things?                        | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 10. Do your hands tremble?                      | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 20. Do you feel you're worthless?                            | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |

Date: 10/08/2022

Candidate/Employee Signature: Balwinder



# RESPIRATORY PROTECTION QUESTIONNAIRE



| CANDIDATE / EMPLOYEE IDENTIFICATION |              |                                    |                                                                                   |                      |          |
|-------------------------------------|--------------|------------------------------------|-----------------------------------------------------------------------------------|----------------------|----------|
| Civil ID / Passport #               | Company ID # | Patient: 26531 Reg. Dt: 10/08/2021 |                                                                                   | Position             |          |
| 94201678                            | 1440         | Name: BALWINDER SINGH              |                                                                                   | RIGGER               |          |
| Nationality                         | Age          | Sex                                | Gender: Male                                                                      | Nationality: (INDIA) | Location |
|                                     |              |                                    | Age: 36Y                                                                          | Mar. Status: Married | BAINDA   |
|                                     |              |                                    | address:                                                                          |                      |          |
|                                     |              |                                    |  |                      |          |

## RESPIRATORY PROTECTION MEDICAL EVALUATION QUESTIONNAIRE - OSHA

Do you use a respirator? ☒ YES ☐ NO What type: ☐ Disposable mask ☐ Canister Mask ☒ SCBA

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ YES ☒ NO

2. Have you ever had any of the following conditions?  
☐ YES ☒ NO a. Seizures ☐ YES ☒ NO c. Trouble smelling odors ☐ YES ☒ NO e. Claustrophobia (fear of closed in places)  
☐ YES ☒ NO b. Diabetes (sugar disease) ☐ YES ☒ NO d. Allergic reactions that interfere with your breathing

3. Have you ever had any of the following pulmonary or lung problems?  
☐ YES ☒ NO a. Asbestosis ☐ YES ☒ NO g. Pneumonia ☐ YES ☒ NO i. Broken ribs  
☐ YES ☒ NO b. Asthma ☐ YES ☒ NO h. Tuberculosis ☐ YES ☒ NO j. Pneumothorax (collapsed lung)  
☐ YES ☒ NO c. Chronic bronchitis ☐ YES ☒ NO i. Silicosis ☐ YES ☒ NO k. Any chest injuries or surgeries  
☐ YES ☒ NO d. Emphysema ☐ YES ☒ NO h. Lung cancer ☐ YES ☒ NO l. Any other lung problem that you have been told about

4. Do you currently have any of the following symptoms of pulmonary or lung illness?  
☐ YES ☒ NO a. Shortness of breath ☐ YES ☒ NO h. Coughing that wakes you early in the morning  
☐ YES ☒ NO b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline ☐ YES ☒ NO i. Coughing that occurs mostly when you are lying down  
☐ YES ☒ NO c. Shortness of breath when walking with other people at an ordinary pace on level ground ☐ YES ☒ NO j. Coughing up blood in the last month  
☐ YES ☒ NO d. Have to stop for breath when walking at your own pace on level ground ☐ YES ☒ NO k. Wheezing  
☐ YES ☒ NO e. Shortness of breath when washing or dressing yourself ☐ YES ☒ NO l. Wheezing that interferes with your job  
☐ YES ☒ NO f. Shortness of breath that interferes with your job ☐ YES ☒ NO m. Chest pain when you breathe deeply  
☐ YES ☒ NO g. Coughing that produces phlegm (thick sputum) ☐ YES ☒ NO n. Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems?  
☐ YES ☒ NO a. Heart attack ☐ YES ☒ NO e. Swelling in your legs or feet (not caused by walking)  
☐ YES ☒ NO b. Stroke ☐ YES ☒ NO f. Heart arrhythmia  
☐ YES ☒ NO c. Angina ☐ YES ☒ NO g. High blood pressure  
☐ YES ☒ NO d. Heart failure ☐ YES ☒ NO h. Any other heart problems that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms?  
☐ YES ☒ NO a. Frequent pain or tightness in your chest ☐ YES ☒ NO e. Heartburn or indigestion that is not related to eating  
☐ YES ☒ NO b. Pain or tightness in your chest during physical activity ☐ YES ☒ NO f. Any other symptoms that you think might be related to heart  
☐ YES ☒ NO c. Pain or tightness in your chest that interferes with your job  
☐ YES ☒ NO d. In the past two years, have you noticed your heart skipping or missing a beat

7. Do you currently take medication for any of the following problems?  
☐ YES ☒ NO a. Breathing or lung problems ☐ YES ☒ NO c. Blood pressure  
☐ YES ☒ NO b. Heart trouble ☐ YES ☒ NO d. Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems?  
☐ YES ☒ NO a. Eye irritation ☐ YES ☒ NO d. General weakness or fatigue  
☐ YES ☒ NO b. Skin allergies or rashes ☐ YES ☒ NO e. Any other problem that interferes with your use of a respirator  
☐ YES ☒ NO c. Anxiety

Date: 10/08/2021 Candidate/Employee Signature: Balwinder



# HEARING CONSERVATION QUESTIONNAIRE



| CANDIDATE / EMPLOYEE IDENTIFICATION |              |                       |                      |          |
|-------------------------------------|--------------|-----------------------|----------------------|----------|
| Govt ID / Passport #                | Company ID # | Ident: 26631          | Reg. Dt: 10/08/202   | Position |
| 94201618                            | 1440         | Name: BALWINDER SINGH |                      | RIGGER   |
| Nationality                         | Age          | Gender: Male          | Nationality: INDIA   | Location |
|                                     |              | Age: 36Y              | Mar. Status: Married | HAIMA    |
|                                     |              |                       |                      |          |

| HEARING CONSERVATION MEDICAL EVALUATION QUESTIONNAIRE - OSHA                                                                                                                                                          |                                                 |                                                                      |                                                  |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|
| Do you use hearing protection? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO What type: <input type="checkbox"/> Earplugs <input type="checkbox"/> Ear Muffs <input type="checkbox"/> Double HP |                                                 |                                                                      |                                                  |                                              |
| 1 - Have you been out of noise for the past 14-16 hours? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                          |                                                 |                                                                      |                                                  |                                              |
| If NO, did you use hearing protection while in the noise? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                    |                                                 |                                                                      |                                                  |                                              |
| 2 - Check ALL of the following activities that you have done or do:                                                                                                                                                   |                                                 |                                                                      |                                                  |                                              |
| <input type="checkbox"/> Hunting                                                                                                                                                                                      | <input type="checkbox"/> Car races              | <input type="checkbox"/> Skeet shooting                              | <input type="checkbox"/> Woodwork                | <input type="checkbox"/> Target shooting     |
| <input type="checkbox"/> Power tools                                                                                                                                                                                  | <input type="checkbox"/> Mower                  | <input type="checkbox"/> Concerts / Band                             | <input type="checkbox"/> Welding                 | <input type="checkbox"/> Air compressor      |
| <input type="checkbox"/> Construction                                                                                                                                                                                 | <input type="checkbox"/> Scuba diving           | <input type="checkbox"/> Tractor (open or closed cab)                |                                                  |                                              |
| Have you ALWAYS used hearing protection when participating in the above activities? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                          |                                                 |                                                                      |                                                  |                                              |
| 3 - Check ALL that you have experienced:                                                                                                                                                                              |                                                 |                                                                      |                                                  |                                              |
| <input type="checkbox"/> Ear Fullness                                                                                                                                                                                 | <input type="checkbox"/> Ear Infections         | <input type="checkbox"/> Ear Surgery                                 | <input type="checkbox"/> Head Injury             | <input type="checkbox"/> Chemotherapy        |
| <input type="checkbox"/> Ringing in the ears                                                                                                                                                                          | <input type="checkbox"/> Ear Pain               | <input type="checkbox"/> Earwax buildup                              | <input type="checkbox"/> Intravenous Antibiotics | <input type="checkbox"/> Hole in the Eardrum |
| <input type="checkbox"/> Ear Drainage                                                                                                                                                                                 | <input type="checkbox"/> Dizziness              |                                                                      |                                                  |                                              |
| 4 - Check ALL that you have had/suffered from:                                                                                                                                                                        |                                                 |                                                                      |                                                  |                                              |
| <input type="checkbox"/> Meningitis                                                                                                                                                                                   | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Measles                                     | <input type="checkbox"/> Syphilis                | <input type="checkbox"/> Chickenpox          |
| <input type="checkbox"/> Mumps                                                                                                                                                                                        | <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Hypertension                                | <input type="checkbox"/> Renal Failure           | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Previous surgery                                                                                                                                                                             | <input type="checkbox"/> Thyroid Problems       | <input type="checkbox"/> Trauma to head/ear canal/ tympanic membrane |                                                  |                                              |
| 5 - Check ALL that you are currently suffering from:                                                                                                                                                                  |                                                 |                                                                      |                                                  |                                              |
| <input type="checkbox"/> Sinusitis                                                                                                                                                                                    | <input type="checkbox"/> Cold/Flu               | <input type="checkbox"/> Ear Infection                               | <input type="checkbox"/> Allergic rhinitis       |                                              |
| 6 - Do you have documented Hearing Loss? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                          |                                                 |                                                                      |                                                  |                                              |
| If Yes: Which Ear(s)? <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both Ear Who performed your hearing test?                                                         |                                                 |                                                                      |                                                  |                                              |
| 7 - Have you EVER worn Hearing Aids? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                              |                                                 |                                                                      |                                                  |                                              |
| If Yes: Which Ear(s)? <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both Ear                                                                                          |                                                 |                                                                      |                                                  |                                              |
| What Size? <input type="checkbox"/> Behind-the-ear <input type="checkbox"/> In-the-ear <input type="checkbox"/> In-the-canal <input type="checkbox"/> Completely-in-the-canal                                         |                                                 |                                                                      |                                                  |                                              |
| What Type? <input type="checkbox"/> Analog <input type="checkbox"/> Digital                                                                                                                                           |                                                 |                                                                      |                                                  |                                              |
| Who fit your hearing aids? <input type="checkbox"/> Licensed Audiologist <input type="checkbox"/> Hearing Aid Dealer <input type="checkbox"/> Don't Know                                                              |                                                 |                                                                      |                                                  |                                              |
| When did you receive your hearing aids?                                                                                                                                                                               |                                                 |                                                                      |                                                  |                                              |
| 8 - Have you ever served in the military? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                         |                                                 |                                                                      |                                                  |                                              |
| If yes, check division <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marines <input type="checkbox"/> National Guard Date: / /              |                                                 |                                                                      |                                                  |                                              |
| Do you have medical disability through the Veterans Administration (VA) for hearing loss or tinnitus? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |                                                 |                                                                      |                                                  |                                              |
| If yes, how much? % What is your TOTAL VA disability? %                                                                                                                                                               |                                                 |                                                                      |                                                  |                                              |
| 9 - Are you currently using any medication <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Which one?                                                                                             |                                                 |                                                                      |                                                  |                                              |
| 10 - What kind of transport do you regularly use? <input type="checkbox"/> Car <input checked="" type="checkbox"/> Bus <input type="checkbox"/> Motorcycle <input type="checkbox"/> Walking                           |                                                 |                                                                      |                                                  |                                              |

Date: 10/08/2025

Candidate/Employee Signature: Balwinder



# PHYSICAL ASSESSMENT FORM



| CANDIDATE / EMPLOYEE IDENTIFICATION |              |                     |          |  |  |
|-------------------------------------|--------------|---------------------|----------|--|--|
| Civil ID / Passport #               | Company ID # | Reg. Dt: 10/08/2022 | Position |  |  |
| 94201678                            | 1440         | 10/08/2022          | RIGGER.  |  |  |
| Nationality                         | Age          | Sex                 | Location |  |  |
|                                     |              |                     | HAIMA    |  |  |

| VITAL SIGNS |         |                            |       |                        |       |
|-------------|---------|----------------------------|-------|------------------------|-------|
| Height      | 181 cm  | Weight                     | 89 kg | BMI                    | 27.17 |
| Pulse       | 76 /min | Medical Practitioner Name: |       | Signature: [Signature] |       |

| VISUAL SYSTEM     |                  |                 |                |                  |                |
|-------------------|------------------|-----------------|----------------|------------------|----------------|
| Right Uncorrected | Left Uncorrected | Right Corrected | Left Corrected | Both Uncorrected | Both Corrected |
| 6/6               | 6/6              |                 |                | 6/6              |                |

| COLOUR VISION TEST |                            |        |          |                   |                          |
|--------------------|----------------------------|--------|----------|-------------------|--------------------------|
| # of Plates passed | Inform the Plates # failed | Normal | Abnormal | Visual Field Test | Stereoscopic Vision Test |
| 10/08/2022         |                            |        |          |                   |                          |

| RESPIRATORY SYSTEM  |                                                                                                               |                                                                               |                                                                     |                                                                                              |  |
|---------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|
| [1] Spirometry Test | Smoking Status                                                                                                | Patient's Posture During Test                                                 | Nose Clips Used                                                     | Diagnosis                                                                                    |  |
|                     | Never <input checked="" type="checkbox"/> Ever Used <input type="checkbox"/> Current <input type="checkbox"/> | Standing <input type="checkbox"/> Sitting <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Other <input type="checkbox"/> |  |

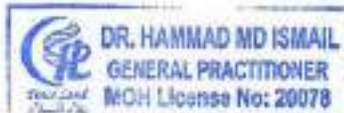
| Acceptability Criteria (as per AARC) |                         | Respiratory Criteria (as per AARC)                                     |                                         |
|--------------------------------------|-------------------------|------------------------------------------------------------------------|-----------------------------------------|
| Free from artifacts                  | Satisfactory exhalation | > 3 acceptable curves FEV1 values AND FVC values within 0.15L (150 ml) | Total of THREE to EIGHT tests performed |
| Good start                           | NOT satisfactory        | The patient CAN NOT or SHOULD NOT continue                             |                                         |

| The Patient Demonstrated:                                                                                  |                                      | Ability to obtain only one good effort |  |
|------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------|--|
| Good Effort <input checked="" type="checkbox"/> Difficulty following instructions <input type="checkbox"/> | Cooperation <input type="checkbox"/> | Signature: [Signature]                 |  |

| [2] Chest Shape and Movement                                                                                       |                              | [3] Air Entry in Both Lungs                                                                                        |                              | [4] Breath sounds                                                                                                  |                              |
|--------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------|
| Normal <input checked="" type="checkbox"/> Abnormal <input type="checkbox"/> Not Examined <input type="checkbox"/> | If abnormal, describe below: | Normal <input checked="" type="checkbox"/> Abnormal <input type="checkbox"/> Not Examined <input type="checkbox"/> | If abnormal, describe below: | Normal <input checked="" type="checkbox"/> Abnormal <input type="checkbox"/> Not Examined <input type="checkbox"/> | If abnormal, describe below: |

| Date of Examination: |  | Physician Name:      |  | Signature:  |  |
|----------------------|--|----------------------|--|-------------|--|
| 10/08/2022           |  | DR. HAMMAD MD ISMAIL |  | [Signature] |  |

| [1] Otoscopy       |                                                                                                                                                  |                                                                                                                                                 |                     | [2] Hearing Test |                                                                                                                |  |  |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------|----------------------------------------------------------------------------------------------------------------|--|--|
| Ear Canal Collapse | Right: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Exam <input type="checkbox"/>                                     | Left: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Exam <input type="checkbox"/>                                     | Eardrum Position    | Whisper Test     | Normal <input checked="" type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam <input type="checkbox"/> |  |  |
| Drainage           | Right: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Exam <input type="checkbox"/>                                     | Left: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Exam <input type="checkbox"/>                                     | Eardrum Vascularity | Rinne Test       | Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam <input type="checkbox"/>            |  |  |
| Perforation        | Right: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Exam <input type="checkbox"/>                                     | Left: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Exam <input type="checkbox"/>                                     |                     | Weber Test       | Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam <input type="checkbox"/>            |  |  |
| Columella          | Right: Normal <input checked="" type="checkbox"/> A lot <input type="checkbox"/> Some <input type="checkbox"/> Not Exam <input type="checkbox"/> | Left: Normal <input checked="" type="checkbox"/> A lot <input type="checkbox"/> Some <input type="checkbox"/> Not Exam <input type="checkbox"/> |                     | Audiometry Done  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                            |  |  |



# PHYSICAL ASSESSMENT FORM

Patient: 26631 Reg. Dt: 10/08/2022  
 Name: BALWINDER SINGH  
 Gender: Male Nationality: (INDIA)  
 Age: 36Y Mar. Status: Married  
 Address:



| ENT SYSTEM                                                                                                                                               |                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>(1) Nose Assessment</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined   | <b>(2) Throat Assessment</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined           |
| <b>CARDIOVASCULAR SYSTEM</b>                                                                                                                             |                                                                                                                                                                    |
| <b>(1) Heart Sounds</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined      | <b>(2) Heart Murmurs</b><br><input type="checkbox"/> Present<br><input checked="" type="checkbox"/> Absent<br><input type="checkbox"/> Not Examined                |
| <b>(3) Peripheral Pulses</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined            | <b>(4) Peripheral Veins</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined            |
| <b>NEUROLOGICAL SYSTEM</b>                                                                                                                               |                                                                                                                                                                    |
| <b>(1) Mental Status</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined     | <b>(2) Cranial Nerves</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined              |
| <b>(3) Motor System</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined      | <b>(4) Reflexes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined                    |
| <b>(5) Sensory System</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined    | <b>(6) Coordination, Station, Gait</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined |
| <b>MUSCULOSKELETAL SYSTEM</b>                                                                                                                            |                                                                                                                                                                    |
| <b>(1) Hand and Wrist</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined    | <b>(2) Elbow and Shoulder</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined          |
| <b>(3) Hip</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined               | <b>(4) Knees</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined                       |
| <b>(5) Foot and Ankle</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined    | <b>(6) Spine and Back</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined              |
| <b>OTHER</b>                                                                                                                                             |                                                                                                                                                                    |
| <b>(1) Skin, Extremities</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined | <b>(2) Head &amp; Neck</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined             |
| <b>(3) Mouth and Teeth</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined   | <b>(4) Genital Organs</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined              |
| <b>(5) Abdominal Organs</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined  | <b>(6) Lymph Nodes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined                 |

Date of Examination: 10/08/2022  
 CQ - Circulation Health Department



DR. HAMMAD MD ISMAIL  
 GENERAL PRACTITIONER  
 MOH License No: 20078

Signature: *[Signature]*  
 Date: 10/08/2022



Peace Land Medical Service LLC, Mukhaizna  
CR No.:2H13627/S, P.O.Box: 1403,  
Postal Code: 133,  
Occidental Camp Mukhaizna, Sultanate of Oman

# PATIENT DETAILS :

|                        |                                         |
|------------------------|-----------------------------------------|
| Patient ID : 28631     | Doc No. : 14806                         |
| Name : BALWINDER SINGH | Doc Date : 2025-08-10T18:16:00          |
| Age : 36Y              | Bill No : 36736                         |
| Gender : Male          | Date : 10/08/2025 18:16 PM              |
| Nationality : INDIAN   | Customer : TRUCKOMAN OIL & GAS SERVICES |
| OSM No : 94768198      | Ref by : DR, HAMMAD ISMAIL              |

# TEST RESULT : OQ-001 OQ MEDICAL CHECKUP

| Test                    | Result          | Normal Range                                                                  | Detailed Description |
|-------------------------|-----------------|-------------------------------------------------------------------------------|----------------------|
| OQ MEDICAL CHECKUP      |                 |                                                                               |                      |
| BLOOD GROUP & Rh TYPING | 'O' Positive    |                                                                               |                      |
| COMPLETE BLOOD COUNT    |                 |                                                                               |                      |
| RBC                     | 5 Million/c     | Male 4.5 - 6.0 million /cu<br>Female 4.5 - 5.5 million/cu                     |                      |
| HAEMOGLOBIN             | 14 gm %         | Male 13 - 18 gm %<br>Female 11 - 15 gm %                                      |                      |
| HCT                     | 41 %            | Male 42 - 52 %<br>Female 37 - 47 %                                            |                      |
| MCV                     | 82 fl           | 76 - 96 fl                                                                    |                      |
| MCH                     | 28 pg           | 27 - 33 pg                                                                    |                      |
| MCHC                    | 33 %            | 32 - 36 %                                                                     |                      |
| WBC COUNT               | 9000 cells/cumm | 4000 - 11 000 cells / cu mm                                                   |                      |
| DIFFERENTIAL COUNT      |                 |                                                                               |                      |
| NEUTROPHIL              | 50 %            | 40-75 %                                                                       |                      |
| LYMPHOCYTE              | 40 %            | 20-45 %                                                                       |                      |
| EOSINOPHIL              | 2 %             | 1-6 %                                                                         |                      |
| MONOCYTE                | 8 %             | 2-8%                                                                          |                      |
| BASOPHIL                | 0 %             | 0-1%                                                                          |                      |
| ESR                     | 3               | Male 0 - 15 mm / 1st hour<br>Female 0 - 20 mm / 1st hour                      |                      |
| PLATELET                | 3.6 lakhs/cumm  | 1.5 - 4.5 lakhs / cu mm                                                       |                      |
| Sickle cells (Screen)   | Negative        |                                                                               |                      |
| LIVER FUNCTION TEST     |                 |                                                                               |                      |
| ALKALINE PHOSPHATASE    | 71 u/l          | 44-147 U/L                                                                    |                      |
| T. BILIRUBIN            | 1.9 mg / dl     | up to 2.0 mg/dl                                                               |                      |
| DIRECT BILIRUBIN        | 0.4 mg / dl     | up to 0.4 mg /dl                                                              |                      |
| INDIRECT BILIRUBIN      | 1.5 mg / dl     | up to 1.6 mg /dl                                                              |                      |
| S.G.O.T.                | 25 u/l          | Male 0-50 u/l<br>Female 0-41 u/l                                              |                      |
| S.G.P.T.                | 34 u/l          | Male 0-45 u/l<br>Female 0-32 u/l                                              |                      |
| T. PROTEIN              | 7 g /dl         | New born 5.2 - 9.1 g /dl<br>Children 5.4 - 8.7 g /dl<br>Adult 6.7 - 8.7 g /dl |                      |
| ALBUMIN                 | 5 g / dl        | 3.6 - 5.5 g/dl                                                                |                      |
| RENAL FUNCTION TEST     |                 |                                                                               |                      |
| UREA                    | 39 mg / dl      | 10-50 mg /dl                                                                  |                      |
| S.CREATININE            | 1 mg / dl       | 0.7 - 1.2 mg /dl                                                              |                      |

Reported By:  
Lab Technician

Sr. Lab Technologist



Verified By:  
Lab Technician

Approved By:  
Lab Technician

Sr. Lab Technologist

Sr. Lab Technologist

Signed at: 10/08/2025 18:18:48

| Test                                | Result      | Normal Range                                                               | Detailed Description                                                                                                                                                                                                                                                                                                        |
|-------------------------------------|-------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| S.URIC ACID                         | 6.9 mg / dl | 3.4 - 7.2 mg /dl                                                           |                                                                                                                                                                                                                                                                                                                             |
| <b>LIPID PROFILE</b>                |             |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Total Cholesterol                   | 181 mg/dl   | Normal < 200 mg/dl<br>Border line : 200 -239 mg / dl<br>High > 240 mg / dl | <p> <b>Patient: 26631</b><br/> <b>Name: BALWINDER SINGH</b><br/> <b>Gender: Male</b><br/> <b>Age: 36Y</b><br/> <b>Address:</b> </p> <p> <b>Reg.Dt: 10/08/202</b><br/> <b>Nationality: (INDIA)</b><br/> <b>Mar. Status: Married</b> </p>  |
| Triglyceride                        | 145 mg/dl   | Normal 0.0 - 150 mg/dl                                                     |                                                                                                                                                                                                                                                                                                                             |
| HDL - CHOL                          | 50 mg/dl    | 35.0 - 79.0 mg /dl                                                         |                                                                                                                                                                                                                                                                                                                             |
| LDL - CHOL                          | 103 mg/dl   | < 130 mg/dl                                                                |                                                                                                                                                                                                                                                                                                                             |
| VLDL                                | 29 mg/dl    | 2-30 mg/dl                                                                 |                                                                                                                                                                                                                                                                                                                             |
| NON HDL CHOLESTEROL                 | 129 mg/dl   | Less than 130mg/dl                                                         |                                                                                                                                                                                                                                                                                                                             |
| FASTING BLOOD SUGAR                 | 96 mg/dl    | 70 - 110 mg/dl                                                             |                                                                                                                                                                                                                                                                                                                             |
| <b>URINE ROUTINE ANALYSIS</b>       |             |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| <b>PHYSICAL</b>                     |             |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Quantity                            | 5 ml        |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Colour                              | Pale yellow |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Sp. Gravity                         | 1.020       |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| pH                                  | Acidic      |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Appearance                          | Clear       |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| <b>CHEMICAL</b>                     |             |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Nitrite                             | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Protein                             | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Glucose                             | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Ketones                             | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Urobilinogen                        | Normal      |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Bilirubin                           | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| Blood                               | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| <b>MICROSCOPIC</b>                  |             |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| PUS_CELLS                           | 1-2         |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| EPITHELIAL CELLS.                   | 1-2         |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| RBCS                                | 1-2         |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| CASTS                               | NIL         |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| CRYSTALS                            | NIL         |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| BACTERIA.                           | NIL         |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| OTHERS.                             | NIL         |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| <b>URINE DRUG SCREEN</b>            |             |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| OPIATE ( URINE )                    | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| MORPHINE ( URINE )                  | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| COCAINE ( URINE )                   | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| AMPHETAMINE ( URINE )               | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| BENZODIAZEPINES (URINE )            | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| PHENCYCLIDINE ( URINE )             | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| METHAMPHETAMINE ( URINE )           | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| TRAMADOL ( URINE )                  | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| BARBITURATES ( URINE )              | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| TRICYCLIC ANTIDEPRESSANTS ( URINE ) | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| METHADONE ( URINE )                 | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |
| ALCOHOL TEST                        | Negative    |                                                                            |                                                                                                                                                                                                                                                                                                                             |

Remarks:




Patient: 26631 Reg. Dt: 10/08/202

Name: BALWINDER SINGH

Gender: Male

Age: 35y

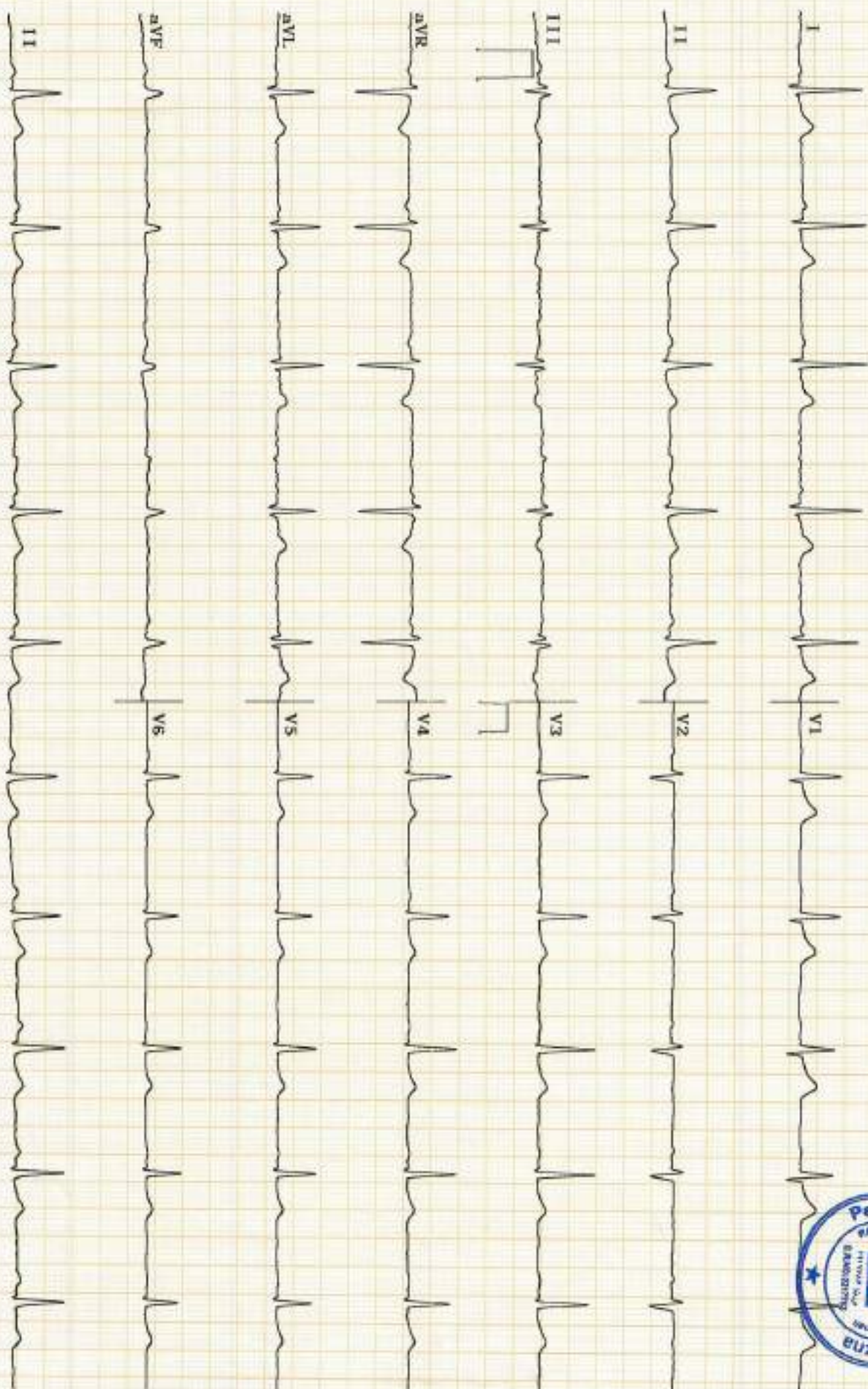
Address:



Heart Rate: 61 bpm  
 PR/RR Int.: 168/984 ms  
 QRS Dur: 96 ms  
 QT/QTc: 404/410 ms  
 P-R-T axes: 59 25 4  
 SV1/RV5/R+S: 0.43/1.23/1.66mV

## Analysis Result ## (To be finally confirmed by physician)  
 Normal Sinus Rhythm  
 [ Normal ECG ]

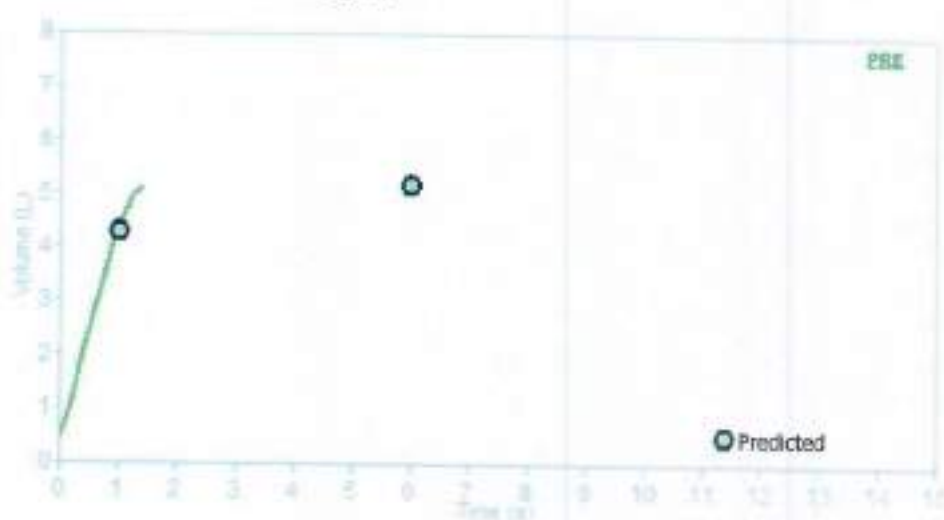
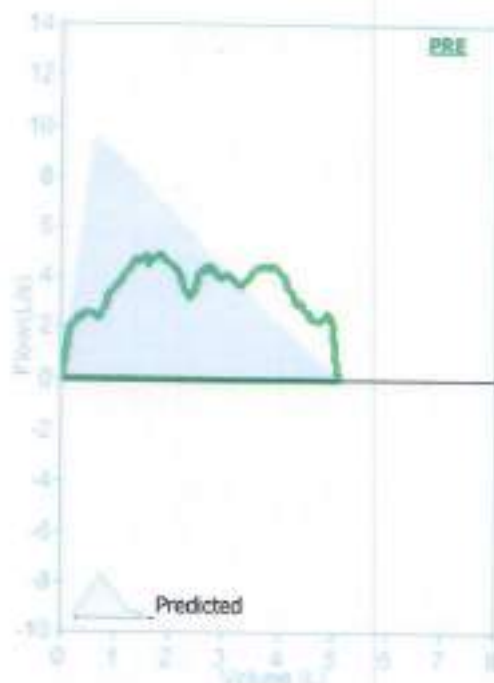
Prescribed by:



# Pulmonary Function Test Results

Visit date 10/08/2025

Patient code 94201678  
 Surname SINGH  
 Name BALWINDER SINGH  
 Date of birth 06/09/1988  
 Ethnic group Caucasian  
 Smoke No smoker  
 Patient group  
 Age 36  
 Gender Male  
 Height, cm 181  
 Weight, kg 89  
 BMI 27.17  
 Pack-Year



Quality Control Grade: F  
 0 Acceptable trials

**Interpretation**  
 Normal Spirometry

PRE Trial date 10/08/2025 08:51:56

| Parameters | LLN   | Pred | Best | %Pred | Z-score | PRE # 1 | PRE # 2 | PRE # 3 | POST | %Pred | %Chg |
|------------|-------|------|------|-------|---------|---------|---------|---------|------|-------|------|
| FVC        | L     | 4.15 | 5.15 | 5.11* | 99      | -0.06   | 5.11    |         |      | *     |      |
| FEV1       | L     | 3.41 | 4.25 | 4.36* | 103     | 0.22    | 4.36    |         |      | *     |      |
| FEV1/FVC   | %     | 68.9 | 80.7 | 85.3* | 106     | 0.64    | 85.3    |         |      | *     |      |
| PEF        | L/s   | 7.72 | 9.72 | 4.93* | 51      | -3.95   | 4.93    |         |      | *     |      |
| ELA        | Years |      | 36   | 36    | 100     |         | 36      |         |      |       |      |
| FEF2575    | L/s   | 2.95 | 4.66 | 4.21  | 90      | -0.44   | 4.21    |         |      |       |      |
| FET        | s     |      | 6.00 | 1.40  | 23      |         | 1.40    |         |      |       |      |
| FVC        | L     | 4.15 | 5.15 |       |         |         |         |         |      |       |      |
| FEV1/VC    | %     | 68.9 | 80.7 |       |         |         |         |         |      |       |      |

\*Best values from all loops - BTPS 1.063 31 °C (87.8 °F) - Predicted ERS (ECCS) / Zapletal

## Conclusion / Medical report

Signature



Instrument used  
 Minispir S S/N C16043

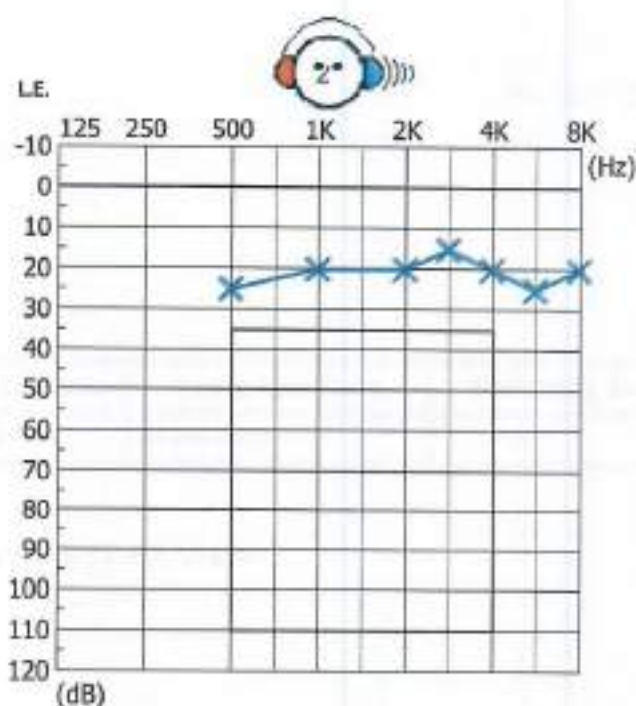
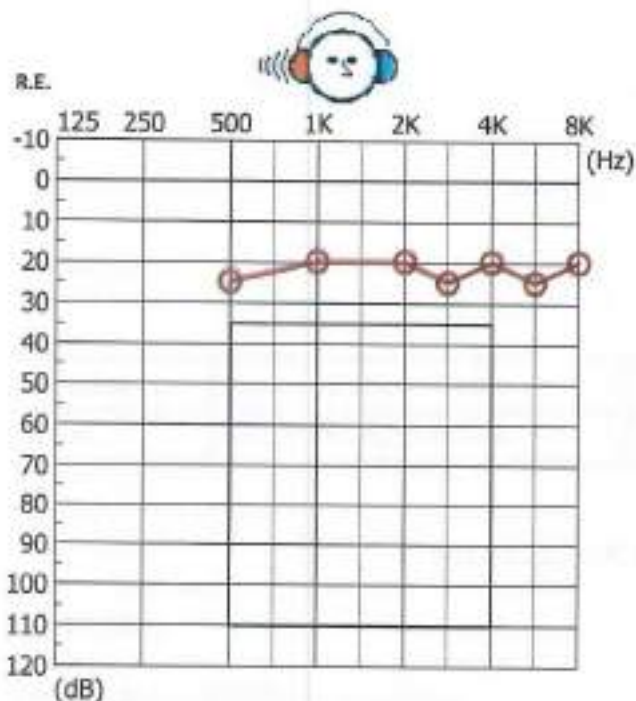
# AUDIOMETRY REPORT

Patient: 26631 Reg. Dt: 10/08/2025  
 Name: BALWINDER SINGH  
 Gender: Male Nationality: INDIA  
 Age: 36Y Mar. Status: Married  
 Address:



## SIBELMED W50

Test date: 10/08/2025  
 Reference: 94201678  
 Technician:  
 Reason:  
 Origin:  
 Equipment: SibelSound DUO  
 Device serial numb.: 910  
 Flash Version: 1.0



### MINISTRY OF LABOUR AND SOCIAL AFFAIRS

|                    | R.E. | L.E. |
|--------------------|------|------|
| Hearing Loss (%)   | 0.0  | 0.0  |
| Average dBs        | 22.5 | 20.0 |
| Bilateral Loss (%) | 0.0  |      |

Right ear: Normal  
 Left ear: Normal

COMMENTS: Normal

*Handwritten signature*



| No Masking  | R.E. | L.E. | With Masking | R.E. | L.E. |
|-------------|------|------|--------------|------|------|
| Air         | ○    | ×    | Air          | △    | □    |
| Bone        | <    | >    | Bone         | =    | =    |
| F. Field    | ⊗    | ⊗    |              |      |      |
| No response | ⊕    | ⊕    |              |      |      |

| Patient Id | Patient Name    | Age/Sex | Procedure Date | Referring Dr |
|------------|-----------------|---------|----------------|--------------|
| 26631      | BALWINDER SINGH | 36Y/M   | 10-08-2025     |              |

**DIGITAL X-RAY CHEST PA VIEW****FINDINGS:**

Trachea and mediastinum in midline.

Both lung fields show normal bronchovascular markings.

Cardiothoracic ratio is within normal limits.

Both cardiophrenic and costophrenic angles are free.

Both domes of diaphragm are normally placed.

Bony ribcage and soft tissue structures appear normal.

**IMPRESSION:**

- NO ABNORMALITIES DETECTED



*[Signature]*  
**Dr. K. VIJAYAKUMAR**  
 MBBS, DMRD  
 Radiologist  
 MOH Lic No.: 7560

Dr. Kumaresan Vijayakumar  
 MBBS, DMRD  
 Radiologist  
 MOH Lic No.: 7560