

Medical Fitness Certificate

Name of the Examined employee: JYOTHILAL SUDHAKARAN

Age: 34

ID NUMBER: 79736586

Job Title:

Date of Medical Examination: 19.11.2020

Examining Physician: DR. KAJAL JOSHI

Medical Centre: APOLLO HOSPITAL MUSCAT

Company:

Assessment Result:

Fit to work without restrictions

This Certificate is valid for 2 years from the date of medical examination

Fitness Classifications:

- Fit to work without restrictions
- Fit to work with restriction
- Unfit to work Temporarily or Definitely

Restrictions List:

R1: Unfit to work offshore, on marine vessels and in remote locations.

R2: Unfit for Lifting and strenuous efforts.

R3: Unfit to work in certain countries, check with geomarket health advisor.

R4: Unfit to work in jobs requiring precise color vision.

R5: Unfit to work in job with high level of noise.

R6: Unfit to work in high risk of malaria countries.

R7: Unfit to work in extreme heat.

R8: Unfit to work in extreme cold.

R9: Contact Geomarket health advisor/international medical coordinator – there exist specific restriction.

R10: Unfit to work for a temporarily of time until further notice.

R11: Unfit to work in jobs requiring good visual acuity (eg: driving company vehicle).

R12: Fit only for defined period of time (1, 3 or 6 months) and must be reassessed and fitness redefined.

R13: Unfit to drive company vehicle.

R14: Unfit to fly long haul flights.

R15: Unfit to work in heights and confined spaces.

Examining Physician Stamp and signature



Hospital/Clinic Seal



CONFIDENTIAL MEDICAL TO BE COMPLETED BY THE EMPLOYEE

| | | | | | | | |
|---|--|-----------------------------------|-------------------------------|---|---|--|--|
| Med-check History Form | | Name: | JYOTHILO sudhakaram | | | | |
| | | GIN # | 79736586 | | | | |
| Place of examination | Date | Mobile # | 98135413 | | | | |
| Age: 34 | Nationality: INDIAN | Blood Group | O+ | | | | |
| <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced | Number of children: | 1 | | | | |
| DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.) | | | | | | | |
| 1. Sinus trouble | Y | N | 21. Cancer | Y | N | HAVE YOU EVER BEEN:- | |
| 2. Neck swelling/glands | | | 22. Heart Disease | | | 40. Rejected for employment or insurance for medical reasons | |
| 3. Difficulty in vision | | | 23. Rheumatic fever | | | 41. Awarded benefits for industrial injury/illness | |
| 4. Any ear discharge | | | 24. Abnormal heartbeat | | | 42. Treated for a mental condition, e.g. depression | |
| 5. Asthma/bronchitis | | | 25. High blood pressure | | | 43. Treated for problem drinking or drug abuse | |
| 6. Hayfever /other significant allergy | | | 26. Stroke | | | 44. Exposed to toxic substance or noise | |
| 7. Any skin trouble | | | 27. Serious chest pain | | | FOR WOMEN ONLY | |
| 8. Tuberculosis | | | 28. Any blood disease | | | Have you ever had:- | |
| 9. Shortness of breath | | | 29. Kidney disease | | | 45. An abnormal smear | |
| 10. Coughed/vomited blood | | | 30. Blood in urine | | | 46. Any gynaecological treatment | |
| 11. Severe abdominal pain | | | 31. Diabetes | | | 47. Are you pregnant? | |
| 12. Stomach ulcer | | | 32. Headaches/migraine | | | 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE | |
| 13. Recurrent indigestion | | | 33. Dizziness/fainting | | | | |
| 14. Jaundice or hepatitis | | | 34. Epilepsy | | | | |
| 15. Gall Bladder disease | | | 35. Joints/spinal trouble | | | | |
| 16. Marked change in bowel habits | | | 36. Surgical operation | | | | |
| 17. Blood in stools (motions) | | | 37. Serious accident/fracture | | | | |
| 18. Marked change in weight | | | 38. Tropical disease | | | | |
| 19. Varicose veins | | | 39. Fear of heights | | | | |
| 20. Lump in breast/armpit | | | | | | | |
| How much tobacco each day? | | Average daily alcohol consumption | | | | | |
| Have you ever taken elicited drugs? () | | | | | | | |
| FAMILY HISTORY: Diabetes (X) Tuberculosis () Epilepsy () Asthma (A) Eczema (X) Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease () Cancer (X) | | | | | | | |
| PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company's Doctors, and the details sent to them by the examining Doctor. | | | | | | | |
| Date: 19/11/2020 | | | | | | | |
| Signature of Applicant:  | | | | | | | |