

Medical Fitness Certificate

Name of the Examined employee: MOHAMMED AFZAL MOKBUL AHMED

Age: 44

ID NUMBER:

Job Title:

Date of Medical Examination: 18.10.2021

Examining Physician:

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 geomarkethealth 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

Dr. SUMRAN IBRAHIM ANSARI
GENERAL PRACTITIONER
MOH Licence No.: 20400
Apollo Hospital Muscat

Hospital/Clinic Seal:



CONFIDENTIAL MEDICAL TO BE COMPLETED BY THE EMPLOYEE

Med-check History Form		Name: <u>MOHAMMED AFZAL MO/CDL</u>	
		GIN #	
Place of examination	Date <u>18-10-2024</u>	Mobile # <u>97145102</u>	
Age: <u>44</u>	Nationality: <u>BANGLADESH</u>	Blood Group	
<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: <u>3</u>	
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)			
	Y	N	
1. Sinus trouble		<input checked="" type="checkbox"/>	21. Cancer
2. Neck swelling/glands		<input checked="" type="checkbox"/>	22. Heart Disease
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure
6. Hay fever /other significant allergy		<input checked="" type="checkbox"/>	26. Stroke
7. Any skin trouble		<input checked="" type="checkbox"/>	27. Serious chest pain
8. Tuberculosis		<input checked="" type="checkbox"/>	28. Any blood disease
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Diabetes
12. Stomach ulcer		<input checked="" type="checkbox"/>	32. Headaches/migraine
13. Recurrent indigestion		<input checked="" type="checkbox"/>	33. Dizziness/fainting
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>	34. Epilepsy
15. Gall Bladder disease		<input checked="" type="checkbox"/>	35. Joints/spinal trouble
16. Marked change in bowel habits		<input checked="" type="checkbox"/>	36. Surgical operation
17. Blood in stools (motions)		<input checked="" type="checkbox"/>	37. Serious accident/fracture
18. Marked change in weight		<input checked="" type="checkbox"/>	38. Tropical disease
19. Varicose veins		<input checked="" type="checkbox"/>	39. Fear of heights
20. Lump in breast/armpit			
How much tobacco each day?		<u>No</u>	Average daily alcohol consumption
Have you ever taken elicited drugs?		<u>(X)</u>	<u>No.</u>
FAMILY HISTORY: Diabetes <u>(X)</u> Tuberculosis <u>(X)</u> Epilepsy <u>(X)</u> Asthma <u>(X)</u> Eczema <u>(X)</u> Heart disease <u>(X)</u> High blood pressure <u>(X)</u> Stroke <u>(X)</u> Blood Disease <u>(X)</u> Cancer <u>(X)</u>			
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: <u>18-10-2024</u>			
Signature of Applicant:			

MD: AFZAL