



## PEACE LAND MEDICAL CENTER



### MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination <i>met</i> Date <i>27/6/21</i>		Surname <i>SANDIP SINGH</i>																																																																																																																															
If a dependant enter employee's name here: Surname: <i>25/12/86</i>		Forenames <i>India</i>																																																																																																																															
Birth date: <i>25/12/86</i> Nationality: <i>Indian</i>		Address <i>COU156291-Truck Oman</i>																																																																																																																															
Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		Forenames: <i>India</i> Country of birth: <i>India</i> Religion: <i>British</i>																																																																																																																															
Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Number of children: <i>0</i>																																																																																																																															
Reason for examination Pre-Employment <input type="checkbox"/> Periodic medical check-up <input type="checkbox"/>		Job: <i>Operator</i>																																																																																																																															
Pre-Overseas <input type="checkbox"/>		Area:																																																																																																																															
Name and address of family doctor		List your last 3 jobs (1) (2) (3)																																																																																																																															
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																																																																																															
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)																																																																																																																																	
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PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.																																																																																																																																	
Date: <i>27/6/21</i>		Signature of Applicant: <i>* Sandip Singh</i>																																																																																																																															



## PEACE LAND MEDICAL CENTER



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE  
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)

### PHYSICAL EXAMINATION

N	A	
/		1. Eyes & Pupils
/		2. E.N.T.
/		3. Teeth & Mouth
/		4. Lungs & Chest
/		5. Cardiovascular System
/		6. Abdo. Viscera
/		7. Hernial Orifices
/		8. Anus & Rectum
/		9. Genito-urinary
/		10. Extremities
/		11. Musculo-skeletal
/		12. Skin & Varicose Vns.
/		13. C.N.S.
		14. Breast

HEIGHT cm	WEIGHT kg	BMI	B.P (MMHG)	PULSE /mins.	HEARING L R	VISION		Colour Vision	Blood Group
						DISTANT R L	NEAR R L		
178	102	32.2	141 90	76	N	Uncorrected 6/6	Corrected 6/6	N	

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
/			/	7. Audiogram
/				8. Lung Function
/				9. Chest X-Ray
				10. ECG
/				11. CVS risk for 40 yrs. & above
/				12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

To regular check of BP.

### ASSESSMENT:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

Date: 28/6/2017 Name (Block Capitals): Dr. / Nurse

Signature: Dr. M. S. URHMAN ABBULLATEEF  
General Practitioner  
NCH License No.: 19486

### REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse

Signature:

