



مجموعة مستشفيات ومستوصفات بدر السماء

BADR AL SAMAA

GROUP OF HOSPITALS & POLYCLINICS

More Than Healthcare ... Humane Care

6504



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

MEDICAL FITNESS CERTIFICATE FOR P.D.O

NAME

ALI ABDULLAH RABIA ABDULLAH AL MASHAYKHI

AGE/D.O.B

46 Y, 29.10.1974

DATE

11.08.2021

PASS/ID NO:

6014999

GENDER

MALE

VISION-RT-EYE

6/6 WITHOUT GLASSES

HEIGHT

170 KG

LT-EYE

6/6 WITHOUT GLASSES

WEIGHT

70 KG

HEART

NORMAL

BP

150/110 mmHg

LUNGS

NORMAL

PULSE

78/Min

ABDOMEN

NORMAL

CNS

NORMAL

SKIN

NORMAL

ENT

NORMAL

INVESTIGATIONS

FBS

NORMAL

BLOOD GROUP

A POSITIVE

HAEMOGRAM

NORMAL

LIPIDPROFILE

NORMAL

RFT

NORMAL

LFT

NORMAL

SICKLING TEST

NEGATIVE

URE

Mild UTI

ECG

LVH

AUDIOGRAM

NORMAL AUDIOMETRIC THRESHOLD

FRAMINGHAM SCORE

Probability of developing cardiovascular disease in next 10 years is 1.8%

COMMENTS

HTN, LEG EDEMA, ECG -LVH

ASSESSMENT DONE IN GOVERNMENT HOSPITAL (HEART FAILURE)

FIT WITH RESTRICTION (OFFICE WORK)

CONCLUSION

MEDICALLY FIT FOR OFFICE WORK

Signature:

DR. AMR AL MASHAYKHI
INTER. MED. & CLINICAL MEDICINE
SPECIALIST
BADR AL SAMAA HOSPITAL, NIZWA

FIT



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Email: info@badroman.com

المقر الرئيسي :

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

روي سلطنة عمان. هاتف : ٢٤٧٩٩٧٦٠، فاكس : ٢٤٧٩٩٧٦٥

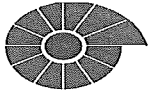
الخوير : ٢٤٤٨٨٣٢٢ | صحار : ٢٤٨٤٦٦٠ | الخوض : ٢٤٥٤٦٩٩ | صلالة : ٢٣٢٩١٨٣

بركاء : ٢٦٨٨٤٩٠ | صور : ٢٥٥٤٦١١٢ | نزوى : ٢٥٤٤٧٧٧٧ | فجلا : ٢٦٥٤١٣١

البريد الإلكتروني : info@badroman.com

Appendix 32: EX1 Form (Initial Examination Report)

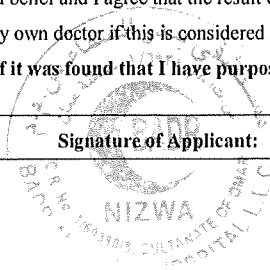
INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

<p>Petroleum Development Oman MEDICAL DEPARTMENT</p> <p>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>		Surname	
		Forenames : <u>Ali Abdullah Rabia</u>	
		Address	
		Home telephone number	
Place of examination BADR AL SAMAA	Date <u>11.08.2021</u>		
If a dependant enter employee's name here:			
Surname:		Forenames:	
Birth date <u>29.10.1974</u>	Nationality:	Country of birth:	Religion:
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
Reason for examination Pre-Employment Job: <input type="checkbox"/>		Number of children:	
Pre-Overseas Area: <input type="checkbox"/>			
Name and address of family doctor		List your last 3 jobs	
		(1)	
		(2)	
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>	
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)			
	Y	N	
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. Hayfever/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?		Average daily alcohol consumption	
Have you ever taken elicited drugs? (<input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs)			
FAMILY HISTORY: Diabetes (<input checked="" type="checkbox"/>) Tuberculosis (<input checked="" type="checkbox"/>) Epilepsy (<input checked="" type="checkbox"/>) Asthma (<input checked="" type="checkbox"/>) Eczema (<input checked="" type="checkbox"/>)			
Heart disease (<input checked="" type="checkbox"/>) High blood pressure (<input checked="" type="checkbox"/>) Stroke (<input checked="" type="checkbox"/>) Blood Disease (<input checked="" type="checkbox"/>) Cancer (<input checked="" type="checkbox"/>)			
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-			
I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.			
Date: <u>11.08.2021</u>		Signature of Applicant:	
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		N							
✓		2. E.N.T.		N							
✓		3. Teeth & Mouth		N							
✓		4. Lungs & Chest		N							
✓		5. Cardiovascular System		leg edema, ECG = LVF							
✓		6. Abdo. Viscera		N							
✓		7. Hernial Orifices		N							
✓		8. Anus & Rectum		N							
✓		9. Genito-urinary		N							
✓		10. Extremities		leg edema							
✓		11. Musculo-skeletal		N							
✓		12. Skin & Varicose Vns.		N							
✓		13. C.N.S.		N							
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	VISION DISTANT NEAR Uncorrected Corrected				Colour Vision	Blood Group
170	70	24.2	150 110	78		R	L	R	L		A+
N	A					LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A
✓		1. Urinalysis									7. Audiogram
✓		2. Hb, Bloodcount, ESR									8. Lung Function
✓		3. LFT, RFT, RBS									9. Chest X-Ray
✓		4. Drug Screen								✓	10. ECG
✓		5. Lipids (40 years +)									11. CVS risk for 40 yrs. & above
✓		6. Sickie Cell test									12. HIV, Hepatitis screening
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)											
Hypertension, leg edema, ECG = LVF for cardiologist opinion											
ASSESSMENT:											
FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input checked="" type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT <input type="checkbox"/>											
Date: _____ Name (Block Capitals): Dr. / Nurse _____ Signature: _____											
REVIEW/CONSULTATION											
Date: _____ Name (Block Capitals): Dr. / Nurse _____ Signature: _____											

Assesment Done before in government hospital -
 (cardiomyopathy) → fit with restriction
 (heart failure) (office work)