



6504



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
LIPID PROFILE	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%

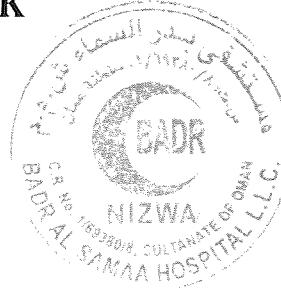
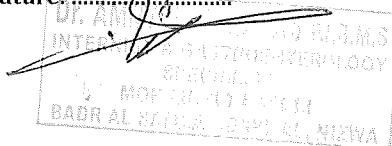
COMMENTS

HTN,LEG EDEMA ,ECG -LVH
ASSESSMENT DONE IN GOVERNMENT HOSPITAL(HEART FAILURE)
FIT WITH RESTRICTION(OFFICE WORK)

CONCLUSION

MEDICALLY FIT FOR OFFICE WORK

Signature:



Headquarters:

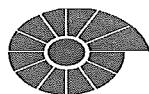
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المقر الرئيسي:

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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

Place of examination BADR AL SAMAA		Surname _____					
		Forenames : <i>Ali Abdullah Rabia</i>					
		Address _____					
		Home telephone number _____					
If a defendant enter employee's name here: Surname: _____		Forenames: _____					
Birth date: <i>29.10.1974</i> 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		Number of children: _____	
Reason for examination Pre-Employment Job: <input type="checkbox"/>		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		Y N		Y N		Y N	
1. Sinus trouble		21. Cancer		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		45. An abnormal smear			
8. Tuberculosis		28. Any blood disease		46. Any gynaecological treatment			
9. Shortness of breath		29. Kidney disease		47. Are you pregnant?			
10. Coughed/vomited blood		30. Blood in urine		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE			
11. Severe abdominal pain		31. Diabetes					
12. Stomach ulcer		32. Headaches/migraine					
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? (<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"/>)	
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: <i>11.08.2021</i>		Signature of Applicant:		NIZWA MEDICAL & DENTAL LLC			
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE Further details of medical history and recreational activities							

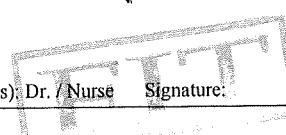
N = Normal A = Abnormal (please describe)			PHYSICAL EXAMINATION								
N	A										
/		1. Eyes & Pupils	N								
/		2. E.N.T.	N								
/		3. Teeth & Mouth	N								
/		4. Lungs & Chest	N								
/		5. Cardiovascular System	leg edema, ECG = LVF								
/		6. Abdo. Viscera	N								
/		7. Hernial 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	DISTANT	VISION NEAR		Colour Vision	Blood Group	
170	70	24.2	150/110	78		Uncorrected Corrected	R L R L R L	W/W W/W W/W W/W W/W W/W	W	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. Sickle Cell test						12. HIV, Hepatitis screening			

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

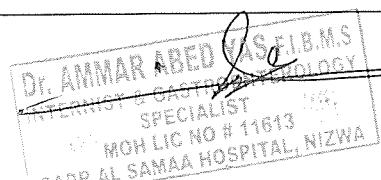
Hypertension, leg edema, ECG = LVF
for Cardiologist's opinion

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

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)