



MEDICAL FITNESS CERTIFICATE FOR P.D.O

NAME

RAJI RABIA KHADOUM AL SAADI

AGE/D.O.B

44 Y, 22.06.1977

DATE

11.08.2021

PASS/ID NO:

8142217

GENDER

MALE

VISION-RT-EYE

6/6 WITHOUT GLASSES

HEIGHT

165 KG

LT-EYE

6/6 WITHOUT GLASSES

WEIGHT

86 KG

HEART

NORMAL

BP

120/70 mmHg

LUNGS

NORMAL

PULSE

72/Min

ABDOMEN

NORMAL

CNS

NORMAL

SKIN

NORMAL

ENT

NORMAL

INVESTIGATIONS

FBS

NORMAL

BLOOD GROUP

O POSITIVE

HAEMOGRAM

NORMAL

LIPIDPROFILE

DLP

RFT

NORMAL

LFT

NORMAL

SICKLING TEST

NEGATIVE

URE

NORMAL

ECG

NORMAL

AUDIOGRAM

NORMAL AUDIOMETRIC THRESHOLD

FRAMINGHAM SCORE

Probability of developing cardiovascular disease in next 10 years is 2.9%

COMMENTS

*

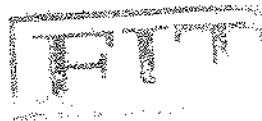
DLP- Advised lifestyle modification

CONCLUSION

MEDICALLY FIT

Signature:

Dr. ANWAR Y. AL-SAYED
 INTERNIST & GASTROENTEROLOGY
 SPECIALIST
 155, MOHAMED N. N. 11613
 BADR AL SAMAA HOSPITAL, NIZWA



Headquarters:

CR. No. 1693808, P.B No. 443, P.C. 112,

Ruwi, Sultanate of Oman, Tel: +968 24799760, Fax: 24799765

Al Khuwair: 24488322 | Sohar: 26846660 | Al Khoud: 24546099 | Salalah: 23291830

Barka: 26884910 | Sur: 25546112 | Nizwa: 25447777 | Falaj: 26754131

Email: info@badroman.com

المقر الرئيسي:

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

روي سلطنة عمان، هاتف: ٢٤٧٩٩٧٦٠، فاكس: ٢٤٧٩٩٧٦٥

الخوير: ٢٤٤٨٨٣٢٢، ص. ب. ٤٤٣، الخوض: ٢٤٥٤٦٩٩، ص. ب. ١١٢

بركاء: ٢٦٨٨٤٩١٠، صور: ٢٥٥٤٦١١٢، نزوى: ٢٥٤٤٧٧٧٧، فلاج: ٢٥٤٤١٣١

البريد الإلكتروني: info@badroman.com

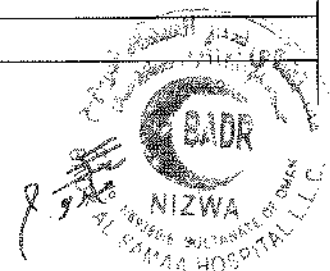
Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman
MEDICAL DEPARTMENT
PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname		Forenames: <u>Karim Karim Khadim Al Saadi</u>	
Address		Home telephone number	
Place of examination BADR AL SAMAA	Date <u>11-06-2014</u>		
If a dependant enter employee's name here:			
Surname:		Forenames:	
Birth date: <u>22-06-1978</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-EmploymentJob: <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		/	21. Cancer
2. Neck swelling/glands		/	22. Heart Disease
3. Difficulty in vision		/	23. Rheumatic fever
4. Any ear discharge		/	24. Abnormal heartbeat
5. Asthma/bronchitis		/	25. High blood pressure
6. Hayfever/other significant allergy		/	26. Stroke
7. Any skin trouble		/	27. Serious chest pain
8. Tuberculosis		/	28. Any blood disease
9. Shortness of breath		/	29. Kidney disease
10. Coughed/vomited blood		/	30. Blood in urine
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? (✓) PDO test all new/potential employees for elicited/recreational drugs			
FAMILY HISTORY: Diabetes (✓) Tuberculosis (✓) Epilepsy (✓) Asthma (✓) Eczema (✓)			
Heart disease (✓) High blood pressure (✓) Stroke (✓) Blood Disease (✓) Cancer (✓)			
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>11-06-2014</u>		Signature of Applicant:	
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE			
Further details of medical history and recreational activities			



Raji

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		N			
/		6. Abdo. Viscera		N			
/		7. Hernial Orifices		N			
/		8. Anus & Rectum		N			
/		9. Genito-urinary		N			
/		10. Extremities		N			
/		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 R L R L Uncorrected Corrected	Colour Vision
165	86	31.4	120 70				
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.)							
DLD. Quitted lifestyle modification							
ASSESSMENT:							
FIT ALL AREAS <input checked="" type="checkbox"/> FIT WITH RESTRICTION <input 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:							

