

## CANDIDATE / EMPLOYEE IDENTIFICATION

| Civil ID / Passport # | Company ID # | Name                | Position     |
|-----------------------|--------------|---------------------|--------------|
| 108911556             | 1634         | MULZATUNNAH HUSSAIN | HEAVY DRIVER |

| Nationality | Age | Sex | Company        | Location |
|-------------|-----|-----|----------------|----------|
| PAKISTANI   | 45  |     | TRUCKMAN NORTH | HAIMA    |

## EXAMINATION TYPE

|             |                                         |                                              |                               |
|-------------|-----------------------------------------|----------------------------------------------|-------------------------------|
| Examination | <input type="checkbox"/> Pre-employment | <input checked="" type="checkbox"/> Periodic | <input type="checkbox"/> Exit |
|-------------|-----------------------------------------|----------------------------------------------|-------------------------------|

## VITAL SIGNS & BODY MEASURES

Blood Pressure Category: 130/80 ☒ Normal ☐ Prehypertension ☐ Hypertension Stage 1 ☐ Hypertension Stage 2 ☐ Hypertension Crises  
BMI Category: 29.1 ☐ Underweight ☐ Normal ☒ Overweight ☐ Obese ☐ Morbid Obesity

Remarks:

## VISUAL TEST

|                         |                                            |                                   |                                       |                                            |                                   |                                   |                                       |
|-------------------------|--------------------------------------------|-----------------------------------|---------------------------------------|--------------------------------------------|-----------------------------------|-----------------------------------|---------------------------------------|
| Visual Acuity Test      | RT 6/6                                     | LT 6/6                            | Visual Field Test                     | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |                                   |                                       |
| Colour Vision Test      | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Not Required | Stereoscopic Vision Test                   | <input type="checkbox"/> Normal   | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Not Required |
| Pre-existing condition: |                                            |                                   |                                       |                                            |                                   |                                   |                                       |
| Remarks:                |                                            |                                   |                                       |                                            |                                   |                                   |                                       |

## RESPIRATORY SYSTEM

|                         |                                                                                                                    |                     |                                                                                                                    |
|-------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------|
| Spirometry Test         | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input checked="" type="checkbox"/> Not Required | Chest X-Ray         | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required |
| Pre-existing condition: |                                                                                                                    | Physical Assessment | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                       |
| Remarks:                |                                                                                                                    |                     |                                                                                                                    |

## ENT SYSTEM

|                         |                                                                                                                    |                     |                                                                                                                    |
|-------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------|
| Audiometry Test         | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required | Otoscopy            | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required |
| Pre-existing condition: |                                                                                                                    | Physical Assessment | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Whisper, Weber & Rinne Tests)        |
| Remarks:                |                                                                                                                    |                     |                                                                                                                    |

## CARDIOVASCULAR SYSTEM

|                         |                                                                                                                    |                     |                                                                              |            |                                                                                                         |
|-------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------|------------|---------------------------------------------------------------------------------------------------------|
| ECG Test                | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required | Physical Assessment | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Framingham | <input type="checkbox"/> Low <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> High |
| Pre-existing condition: |                                                                                                                    |                     |                                                                              |            |                                                                                                         |
| Remarks:                |                                                                                                                    |                     |                                                                              |            |                                                                                                         |

## NEUROLOGICAL SYSTEM

|                         |                                                                              |
|-------------------------|------------------------------------------------------------------------------|
| Physical Assessment     | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| Pre-existing condition: |                                                                              |
| Remarks:                |                                                                              |

## MUSCULOSKELETAL SYSTEM

|                         |                                                                              |              |                                                                                                                    |
|-------------------------|------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------|
| Physical Assess.        | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Lumbar X-Ray | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input checked="" type="checkbox"/> Not Required |
| Pre-existing condition: |                                                                              |              |                                                                                                                    |
| Remarks:                |                                                                              |              |                                                                                                                    |

## LABORATORY INVESTIGATIONS

|                         |                                                                                                                 |                |             |
|-------------------------|-----------------------------------------------------------------------------------------------------------------|----------------|-------------|
| Lab Tests               | <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Abnormal If abnormal, please specify below: | Blood Grouping | <u>B+ve</u> |
| Pre-existing condition: | <u>INTERNAL MEDICINE CONSULTATION FOR</u>                                                                       |                |             |
| Remarks:                | <u>HIGH LIPID PROFILE</u>                                                                                       |                |             |

Glucose Level Category: 100mg/dl ☒ Normal 80 – 100 mg/dl ☐ Pre-diabetic 100 – 125 mg/dl ☐ Diabetic > 125 mg/dl  
Cholesterol Risk Category: 202mg/dl ☐ Low Risk LDL is less 130 mg/dl ☐ Moderate Risk LDL 130-159 mg/dl ☒ High Risk LDL >160 mg/dl  
Routine Urine Analysis ☐ Normal ☐ Abnormal ☐ Not Required Stool Analysis ☐ Normal ☐ Abnormal ☐ Not Required

## QUESTIONNAIRES

|                                          |                                                                                                                                                                                                                                                                                                       |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Medical & Surgical History Questionnaire | Remarks                                                                                                                                                                                                                                                                                               |
| Respiratory Protection Questionnaire     | Remarks                                                                                                                                                                                                                                                                                               |
| Hearing Conservation Questionnaire       | Remarks                                                                                                                                                                                                                                                                                               |
| Screening Questionnaire                  | Remarks                                                                                                                                                                                                                                                                                               |
| Fagerstrom Test - Smoking                | <input type="checkbox"/> Non-smoker <input type="checkbox"/> Low dependence <input type="checkbox"/> Low to Mod dependence <input type="checkbox"/> Moderate dependence <input type="checkbox"/> High dependence                                                                                      |
| CAGE Questionnaire Alcohol Use           | <input type="checkbox"/> No use of alcohol <input type="checkbox"/> Screening positive <input type="checkbox"/> Clinically significant                                                                                                                                                                |
| SRQ-20 Self-reported Questionnaire       | <input type="checkbox"/> No positive answers <input type="checkbox"/> Positive answers Factor I (1 to 6) <input type="checkbox"/> Positive answers Factor II (7 to 12) <input type="checkbox"/> Positive answers Factor III (13 to 15) <input type="checkbox"/> Positive answers Factor IV (16 to 20) |

|                    |           |          |                                 |            |
|--------------------|-----------|----------|---------------------------------|------------|
| Clinic Doctor Name | License # | Hospital | Doctor Signature & Clinic Stamp | Issue Date |
|--------------------|-----------|----------|---------------------------------|------------|



**OQEP Occupational Health**  
**FITNESS TO WORK CERTIFICATE [CONTRACTOR]**

OQEP-COR-HSE-HEL-FRM-00021

Classification: External Use

Review: 03-31/08/2024

**EMPLOYEE IDENTIFICATION**

|                  |     |                       |            |                        |                       |
|------------------|-----|-----------------------|------------|------------------------|-----------------------|
| Company          |     | Identification Number |            | Client: 16088          | Reg. Dt: 30/10/202    |
| TRUCK ONAN NORTH |     | 108911556             |            | Name: MUZAMMAL HUSSAIN |                       |
| Nationality      | Age | Sex                   | Entry Date | Gender: Male           | Nationality: PAKISTAN |
|                  |     |                       | 30/10/2025 | Age: 45y               | Mar. Status: Married  |
|                  |     |                       | Location   | Job Title              |                       |
|                  |     |                       | HAINA      | HD DRIVER              |                       |



**MEDICAL SUITABILITY FOR WORK**

|                              |                                                 |                                              |                                                |                                       |                                       |                                          |
|------------------------------|-------------------------------------------------|----------------------------------------------|------------------------------------------------|---------------------------------------|---------------------------------------|------------------------------------------|
| Medical Evaluation Type      | <input type="checkbox"/> Pre-employment         | <input checked="" type="checkbox"/> Periodic | <input type="checkbox"/> Exit                  | <input type="checkbox"/> Job Transfer | <input type="checkbox"/> Post-absence | <input type="checkbox"/> Cause Triggered |
| Medical Suitability for Work | <input checked="" type="checkbox"/> Fit to Work | <input type="checkbox"/> Unfit               | <input type="checkbox"/> Fit with Restrictions |                                       |                                       |                                          |

**FIT**

**Restrictions**

|                                                          |                                                  |                                                                       |
|----------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Working at height               | <input type="checkbox"/> Heavy lifting operation | <input type="checkbox"/> Pulling, pushing or carrying weight          |
| <input type="checkbox"/> Working in confined space       | <input type="checkbox"/> Emergency response duty | <input type="checkbox"/> Ascend/descend ladders and stairs            |
| <input type="checkbox"/> Working with electricity        | <input type="checkbox"/> Manual cargo handling   | <input type="checkbox"/> Walking or standing for long distance/period |
| <input type="checkbox"/> Working near rotating machinery | <input type="checkbox"/> Deep excavation         | <input type="checkbox"/> Repetitive movements                         |
| <input type="checkbox"/> Driving vehicles                | <input type="checkbox"/> Food handling           | <input type="checkbox"/> Handling chemical products                   |
| <input type="checkbox"/> Mobile machinery operation      | <input type="checkbox"/> Working in noise area   | <input type="checkbox"/> Working in extreme heat                      |

Other, specify

|                  |                                                         |                                    |
|------------------|---------------------------------------------------------|------------------------------------|
| Restriction Type | <input type="checkbox"/> Temporary until ____/____/____ | <input type="checkbox"/> Permanent |
|------------------|---------------------------------------------------------|------------------------------------|

Annotations:

fit to work as per specialist report.



|                      |                 |          |                  |
|----------------------|-----------------|----------|------------------|
| Doctor Name          | Medical License | Hospital | Doctor Signature |
| DR. HAMMAD MD ISMAIL |                 |          |                  |



## CANDIDATE / EMPLOYEE IDENTIFICATION

|                       |              |                                                                                                                                                                 |              |
|-----------------------|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| Civil ID / Passport # | Company ID # | Patient: 16088      Reg. Dt: 30/10/202<br>Name: MUHAMMAD MUHAMMAD<br>Gender: Male      Nationality: PAKISTANI<br>Age: 45y      Mar. Status: Married<br>Address: | Position     |
| 10891556              | 1634         |                                                                                                                                                                 | HEAVY DRIVER |
| Nationality           | Age          | Sex                                                                                                                                                             | Location     |
|                       |              |                                                                                                                                                                 | HAIMA        |

## VITAL SIGNS

|         |                            |      |                |
|---------|----------------------------|------|----------------|
| Height  | Weight                     | BMI  | Blood Pressure |
| 172 cm  | 86 Kg                      | 29.1 | 130/80 mmHg    |
| Pulse   | Medical Practitioner Name: |      | Signature:     |
| 76 /min |                            |      |                |

## VISUAL SYSTEM

|                    |                   |                  |                 |                |                  |                |
|--------------------|-------------------|------------------|-----------------|----------------|------------------|----------------|
| Visual Acuity Test | Right Uncorrected | Left Uncorrected | Right Corrected | Left Corrected | Both Uncorrected | Both Corrected |
|                    | 6/6               | 6/6              |                 |                | 6/6              |                |

|                               |                    |                            |                   |                          |
|-------------------------------|--------------------|----------------------------|-------------------|--------------------------|
| Colour Vision Test (Ishihara) | # of Plates passed | Inform the Plates # failed | Visual Field Test | Stereoscopic Vision Test |
|                               |                    |                            |                   |                          |

|                                 |                            |            |
|---------------------------------|----------------------------|------------|
| Date of Examination: 30/10/2025 | Medical Practitioner Name: | Signature: |
|                                 |                            |            |

## RESPIRATORY SYSTEM

[1] Spirometry Test

Smoking Status: ☐ Never ☐ Ever Used ☐ Current      Patient's Posture During Test: ☐ Standing ☐ Sitting      Nose Clips Used: ☐ Yes ☐ No

Diagnosis: ☐ Asthma ☐ COPD ☐ Other

|                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Acceptability Criteria (select all that is applicable):<br><input type="checkbox"/> Free from artifacts <input type="checkbox"/> Satisfactory exhalation<br><input type="checkbox"/> Good start <input type="checkbox"/> NOT satisfactory | Repeatability Criteria (select all that is applicable):<br><input type="checkbox"/> >3 acceptable curves FEV1 values AND FVC values within 0.15L (150 ml)<br><input type="checkbox"/> Total of THREE to EIGHT tests performed<br><input type="checkbox"/> The patient CAN NOT or SHOULD NOT continue |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

The Patient Demonstrated: ☐ Good Effort ☐ Difficulty following instructions ☐ Ability to obtain only one good effort ☐ Poor Effort ☐ Cooperation

Date of Examination:      Medical Practitioner Name:      Signature:

|                                                                                                              |                                                                                                      |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| [2] Chest Shape and Movement<br><input checked="" type="checkbox"/> Normal      If abnormal, describe below: | [3] Chest Percussion<br><input checked="" type="checkbox"/> Normal      If abnormal, describe below: |
| <input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined                                   | <input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined                           |

|                                                                                                             |                                                                                                   |
|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| [3] Air Entry in Both Lungs<br><input checked="" type="checkbox"/> Normal      If abnormal, describe below: | [4] Breath sounds<br><input checked="" type="checkbox"/> Normal      If abnormal, describe below: |
| <input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined                                  | <input type="checkbox"/> Abnormal<br><input type="checkbox"/> Not Examined                        |

Date of Examination: 30/10/2025      Physician Name:      Signature:

## ENT-SYSTEM

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| [1] Otoscopy<br>Ear Canal Collapse: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Exam<br>Drainage: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Exam<br>Perforation: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Exam<br>Cerumen: <input type="checkbox"/> None <input type="checkbox"/> A lot <input type="checkbox"/> Impacted <input type="checkbox"/> Not Exam | Eardrum Position: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Retracted <input type="checkbox"/> Bulging <input type="checkbox"/> Not Exam<br>Eardrum Vascularity: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Considerable <input type="checkbox"/> Mild <input type="checkbox"/> Not Exam | [2] Hearing Test<br>Whisper Test: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam<br>Rinne Test: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam<br>Weber Test: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam<br>Audiometry Done: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Hearing Questionnaire verified: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## ENT SYSTEM

### [2] Nose Assessment

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [3] Throat Assessment

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

Patient: 16088

Name: MUZAMMA

Gender: Male

Age: 45y

Address:

Reg. Dt: 30/10/

HUSSAIN

Nationality: PAKIST

Mar. Status: Mar

## CARDIOVASCULAR SYSTEM

### [1] Heart Sounds

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [2] Heart Murmurs

- ☐ Present  
☒ Absent  
☐ Not Examined

If present, describe below:

### [3] Peripheral Pulses

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [4] Peripheral Veins

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

## NEUROLOGICAL SYSTEM

### [1] Mental Status

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [2] Cranial Nerves

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [3] Motor System

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [4] Reflexes

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [5] Sensory System

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [6] Coordination, Station, Gait

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

## MUSCULOSKELETAL SYSTEM

### [1] Hand and Wrist

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [2] Elbow and Shoulder

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [3] Hip

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [4] Knee

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [5] Foot and Ankle

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [6] Spine and Back

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

## OTHER

### [1] Skin, Extremities

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [2] Head & Neck

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [3] Mouth and Teeth

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [4] Genital Orifices

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [5] Abdominal Organs

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:

### [6] Lymph Nodes

- ☒ Normal  
☐ Abnormal  
☐ Not Examined

If abnormal, describe below:



Date of Examination: 30/10/2025 Physician Name:

OQEP Occupational Health Requirements for Contractors



Signature: [Signature]

## CANDIDATE / EMPLOYEE IDENTIFICATION

|                       |              |                                                                                 |                                                                     |                                                                                      |
|-----------------------|--------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| Civil ID / Passport # | Company ID # | Client: 16088<br>Name: MUZAMMAL HUSSAIN<br>Gender: Male<br>Age: 43y<br>Address: | Reg. Dt: 30/10/202<br>Nationality: PAKISTAN<br>Mar. Status: Married | Position<br><br><div style="font-size: 1.2em; font-weight: bold;">HEAVY DRIVER</div> |
| Nationality           | Age          | Sex                                                                             |                                                                     | Location<br><br><div style="font-size: 1.2em; font-weight: bold;">HAIMA</div>        |

## PERSONAL HEALTH HISTORY

Have you ever, or do you currently suffer from any of the following?

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <p>Congenital heart disease or Valvular heart disease or Coronary artery disease <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Myocardial insufficiency or infarction (heart attack) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Coronary bypass surgery (CABS) and angioplasty <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Heart arrhythmias (heart beats too fast, too slow or irregularly) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>High blood pressure (hypertension) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Shortness of breath after exertion <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Varicose veins associated with varicose eczema, ulcers or other complications <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Arteriosclerotic or other vascular disease <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Anemias, especially Sickle Cell Disease or Sickle Cell Trait or Thalassemia, G6PD <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Haemorrhage disorders i.e. bleeding disorders <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Leukaemia, polycythaemia and disorders of the reticulo-endothelial system <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Recurrent headaches or migraine <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Epilepsy and recurrent seizures <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Blackouts, dizziness, fainting, memory loss, unconsciousness (vertigo/syncope) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Sleep disorders, such as insomnia, hypersomnia, sleep apnea, narcolepsy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Chronic anxiety states and/or recurrent depression <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Phobias such as fear of heights, fear of confined spaces, fear of flying <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Lung disease e.g. bronchitis, asthma, dyspnea, Tuberculosis (TB) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Phlegm production (excess mucus production) or tight chest <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Immuno suppression due to cancer or human immunodeficiency virus <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Lump in breast or armpit <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> | <p>Muscle problems e.g. weakness of your limbs or twitchy muscles <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Joint problems, e.g. plantar warts, joint pain or swelling <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Problems with limb, neck or spine mobility <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Extremities (feet or hands) deformities or problems <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Experienced back problem, arthritis, slipped disc <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Pain in neck or back or hands or legs <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Thyroid disease or any other glandular diseases <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Diabetes mellitus or Hypoglycemia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Experienced unintentional weight loss or gain &gt; 5kg over the past year <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Informed about being overweight or obese <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skin disorders e.g. severe acne, dermatitis, eczema or allergy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Allergies e.g. dust, medication, insect bites, chemicals <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Disorders of the digestive tract e.g. ulcers, recurrent diarrhea, gastritis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Haemorrhoids, fistulae and fissures causing pain, or recurrent bleeding <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Liver and pancreas diseases (e.g. pancreatitis, Hepatitis, Jaundice) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Kidney or bladder diseases e.g. recurrent infection, renal stones <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Ear, nose or throat problems (e.g. otitis, hearing loss, sinusitis, tonsillitis) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Eye disease or visual defect (e.g. glaucoma, color blindness, monocular vision) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Treated for infectious diseases (e.g. malaria, COVID19, dengue) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Treated for mental health problems, such as depression, stress, anxiety <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Treated for substance or alcohol abuse <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------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Any other diseases not mentioned in the above list? ☒ No ☐ Yes, please specify:

Any disabilities and compensations received? ☒ No ☐ Yes, please specify:

Have you visited a doctor in the last year? ☐ Yes ☒ No

Are you taking any medication at present? ☐ Yes ☒ No

Are you pregnant? ☐ Yes ☒ No

Date: 30/10/2025

### List any previous injuries or operations

| Previous injuries or operations | Date |
|---------------------------------|------|
|                                 |      |
|                                 |      |
|                                 |      |

Candidate/Employee Signature

*[Signature]*



Peace Land Medical Service LLC, Mukhalaza  
CR No.:2/13627/3, P.O.Box: 1403,  
Postal Code: 133,  
Occidental Camp Mukhalaza, Sultanate of Oman

PATIENT DETAILS :

|                         |                                         |
|-------------------------|-----------------------------------------|
| Patient ID : 16088      | Doc No : 15635                          |
| Name : MUZAMMAL HUSSAIN | Doc Date : 2025-10-30T10:40:00          |
| Age : 45Y               | Bill No : 38051                         |
| Gender : Male           | Date : 30/10/2025 10:40 AM              |
| Nationality : PAKISTANI | Customer : TRUCKOMAN OIL & GAS SERVICES |
| GSM No : 93227071       | Ref by : DR.HASHIM ABDALLAH             |

TEST RESULT : OQ-001 OQ MEDICAL CHECKUP

| Test                    | Result          | Normal Range                                                                  | Detailed Description |
|-------------------------|-----------------|-------------------------------------------------------------------------------|----------------------|
| OQ MEDICAL CHECKUP      |                 |                                                                               |                      |
| BLOOD GROUP & Rh TYPING | 'B' Positive    |                                                                               |                      |
| COMPLETE BLOOD COUNT    |                 |                                                                               |                      |
| RBC                     | 5.8 Million/c   | Male 4.5 - 6.0 million /cu<br>Female 4.5 - 5.5 million/cu                     |                      |
| HAEMOGLOBIN             | 16.1 gm %       | Male 13 - 18 gm %<br>Female 11 - 15 gm %                                      |                      |
| HCT                     | 45 %            | Male 42 - 52 %<br>Female 37 - 47 %                                            |                      |
| MCV                     | 80 fl           | 78 - 96 fl                                                                    |                      |
| MCH                     | 28 pg           | 27 - 33 pg                                                                    |                      |
| MCHC                    | 35 %            | 32 - 36 %                                                                     |                      |
| WBC COUNT               | 4500 cells/cumm | 4000 - 11 000 cells / cu mm                                                   |                      |
| DIFFERENTIAL COUNT      |                 |                                                                               |                      |
| NEUTROPHIL              | 47 %            | 40-75 %                                                                       |                      |
| LYMPHOCYTE              | 42 %            | 20-45 %                                                                       |                      |
| EOSINOPHIL              | 3 %             | 1-6 %                                                                         |                      |
| MONOCYTE                | 6 %             | 2-8%                                                                          |                      |
| BASOPHIL                | 0 %             | 0-1%                                                                          |                      |
| ESR                     | 5               | Male 0 - 15 mm / 1st hour<br>Female 0 - 20 mm / 1st hour                      |                      |
| PLATELET                | 2.3 lakhs/cumm  | 1.5 - 4.5 lakhs / cu mm                                                       |                      |
| Sickle cells (Screen)   | Negative        |                                                                               |                      |
| LIVER FUNCTION TEST     |                 |                                                                               |                      |
| ALKALINE PHOSPHATASE    | 75 u/l          | 44-147 U/L                                                                    |                      |
| T. BILIRUBIN            | 0.8 mg / dl     | up to 2.0 mg/dl                                                               |                      |
| DIRECT BILIRUBIN        | 0.2 mg / dl     | up to 0.4 mg /dl                                                              |                      |
| INDIRECT BILIRUBIN      | 0.6 mg / dl     | up to 1.6 mg /dl                                                              |                      |
| S.G.O.T.                | 17 u/l          | Male 0-50 u/l<br>Female 0-41 u/l                                              |                      |
| S.G.P.T.                | 33 u/l          | Male 0-45 u/l<br>Female 0-32 u/l                                              |                      |
| T. PROTEIN              | 8 g /dl         | New born 5.2 - 8.1 g /dl<br>Children 5.4 - 8.7 g /dl<br>Adult 6.7 - 8.7 g /dl |                      |
| ALBUMIN                 | 4.5 g / dl      | 3.5 - 5.5 g/dl                                                                |                      |
| RENAL FUNCTION TEST     |                 |                                                                               |                      |
| UREA                    | 29 mg / dl      | 10-50 mg /dl                                                                  |                      |

Reported By:  
Lab Technician

Verified By:  
Lab Technician

Approved By:  
Lab Technician

Sr. Lab Technologist

Sr. Lab Technologist

Sr. Lab Technologist

Printed at: 30/10/2025 10:44:23

Signed at: 30/10/2025 10:44:23



| Test                                | Result      | Normal Range                                                               | Detailed Description |
|-------------------------------------|-------------|----------------------------------------------------------------------------|----------------------|
| S.CREATININE                        | 0.7 mg / dl | 0.7 - 1.2 mg /dl                                                           |                      |
| S.URIC ACID                         | 5.8 mg / dl | 3.4 - 7.2 mg /dl                                                           |                      |
| LIPID PROFILE                       |             |                                                                            |                      |
| Total Cholesterol                   | 381 mg/dl   | Normal < 200 mg/dl<br>Border line : 200 -239 mg / dl<br>High > 240 mg / dl |                      |
| Triglyceride                        | 487 mg/dl   | Normal 0.0 - 150 mg/dl                                                     |                      |
| HDL - CHOL                          | 45 mg/dl    | 35.0 - 70.0 mg /dl                                                         |                      |
| LDL - CHOL                          | 292 mg/dl   | < 130 mg/dl                                                                |                      |
| FASTING BLOOD SUGAR                 | 100 mg/dl   | 70 - 110 mg/dl                                                             |                      |
| URINE ROUTINE ANALYSIS              |             |                                                                            |                      |
| PHYSICAL                            |             |                                                                            |                      |
| Quantity                            | 5 ml        |                                                                            |                      |
| Colour                              | Pale yellow |                                                                            |                      |
| Sp. Gravity                         | 1.010       |                                                                            |                      |
| pH                                  | Acidic      |                                                                            |                      |
| Appearance                          | Clear       |                                                                            |                      |
| CHEMICAL                            |             |                                                                            |                      |
| Nitrite                             | Negative    |                                                                            |                      |
| Protein                             | Negative    |                                                                            |                      |
| Glucose                             | Negative    |                                                                            |                      |
| Ketones                             | Negative    |                                                                            |                      |
| Urobilinogen                        | Normal      |                                                                            |                      |
| Bilirubin                           | Negative    |                                                                            |                      |
| Blood                               | Negative    |                                                                            |                      |
| MICROSCOPIC                         |             |                                                                            |                      |
| PUS_CELLS                           | 1-2         |                                                                            |                      |
| EPITHELIAL CELLS.                   | 1-2         |                                                                            |                      |
| RBCS                                | 1-2         |                                                                            |                      |
| CASTS                               | NIL         |                                                                            |                      |
| CRYSTALS                            | NIL         |                                                                            |                      |
| BACTERIA.                           | NIL         |                                                                            |                      |
| OTHERS.                             | NIL         |                                                                            |                      |
| URINE DRUG SCREEN                   |             |                                                                            |                      |
| OPIATE ( URINE )                    | Negative    |                                                                            |                      |
| MORPHINE ( URINE )                  | Negative    |                                                                            |                      |
| COCAINE ( URINE )                   | Negative    |                                                                            |                      |
| AMPHETAMINE ( URINE )               | Negative    |                                                                            |                      |
| BENZODIAZEPINES (URINE )            | Negative    |                                                                            |                      |
| PHENCYCLIDINE ( URINE )             | Negative    |                                                                            |                      |
| METHAMPHETAMINE ( URINE )           | Negative    |                                                                            |                      |
| TRAMADOL ( URINE )                  | Negative    |                                                                            |                      |
| BARBITURATES ( URINE )              | Negative    |                                                                            |                      |
| TRICYCLIC ANTIDEPRESSANTS ( URINE ) | Negative    |                                                                            |                      |
| METHADONE ( URINE )                 | Negative    |                                                                            |                      |
| ALCOHOL TEST                        | Negative    |                                                                            |                      |

Remarks:

*[Signature]*

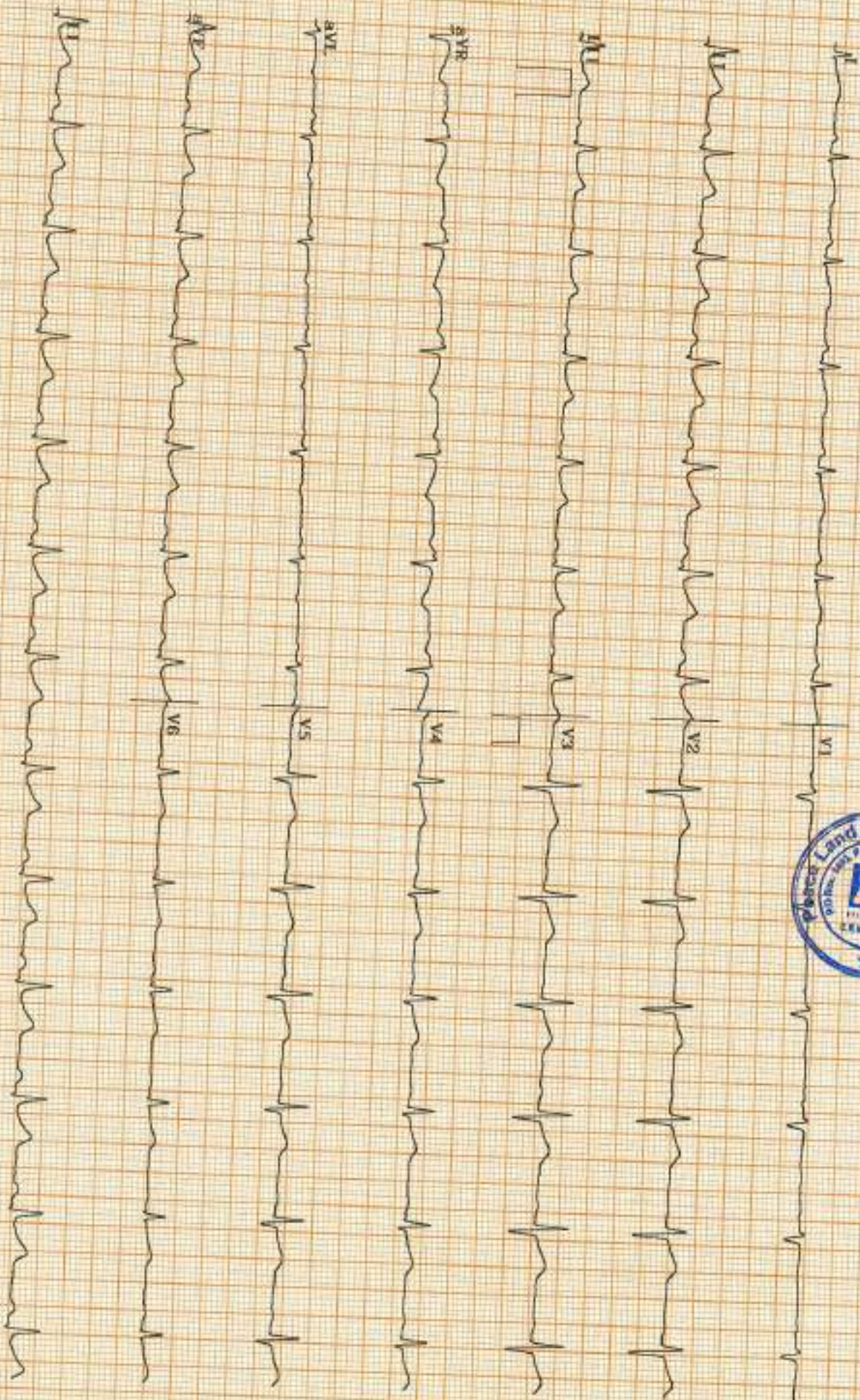


Patient: 16088 Reg. On: 30/10/202  
Name: MUZAMMAL MUSTAN  
Gender: Male Nationality: PAKISTAN  
Age: 45y Mar. Status: Married  
Address:



PR/RR Int.: 1172/789 ms  
QRS Dur.: 104 ms  
QT/QTc: 432/481 ms  
P-R-T axes: 46 66 66  
SV1/RV5/R+S: 0.56/1.05/1.61mV

Analysis Result: (To be finally confirmed by physician)  
Normal Sinus Rhythm  
[ Normal ECG ]



Rate: 0Hz LPP: 100Hz AC: 50Hz PMG: On

10.0/5.0mm/mV 25.0mm/sec

EXG2000 6.00/3.24 Blomlet Co., Ltd.



بلاد السلام للخدمات الطبية ش.م.م.  
Peace Land Medical Services L.L.C

PATIENT ID 16088

### Estimated 10-year Global CVD Risk

11.20%

### Risk Category

Moderate Risk

### Estimated Vascular Age

57 Years

### Treatment Guidelines

#### ATP-III (2004)

##### Treatment Targets

LDL <130 mg/dL (<3.37 mmol/L)

Non-HDL <160 mg/dL (<4.14 mmol/L)

#### CCS (2009)

##### Initiate Pharmacotherapy if

LDL >3.5 mmol/L (>135 mg/dL)

TChol/HDL-C >5 mmol/L (>193 mg/dL)

hsCRP >2 mg/L in men >50 years and women >60 years

FHx and moderate risk hsCRP

##### Treatment Targets

LDL <2 mmol/L (<77 mg/dL) or ≥50 % decrease in LDL-C

apoB <0.8 g/L (80 mg/dL)

#### ESC (2007, see Info for more)

##### Treatment Targets

LDL <3 mmol/L (<120 mg/dL)

TChol <5 mmol/L (<194 mg/dL)



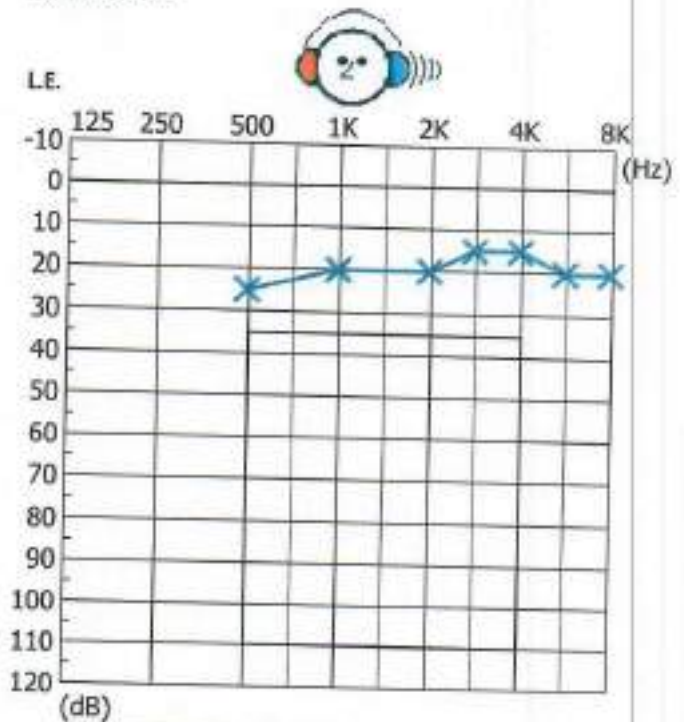
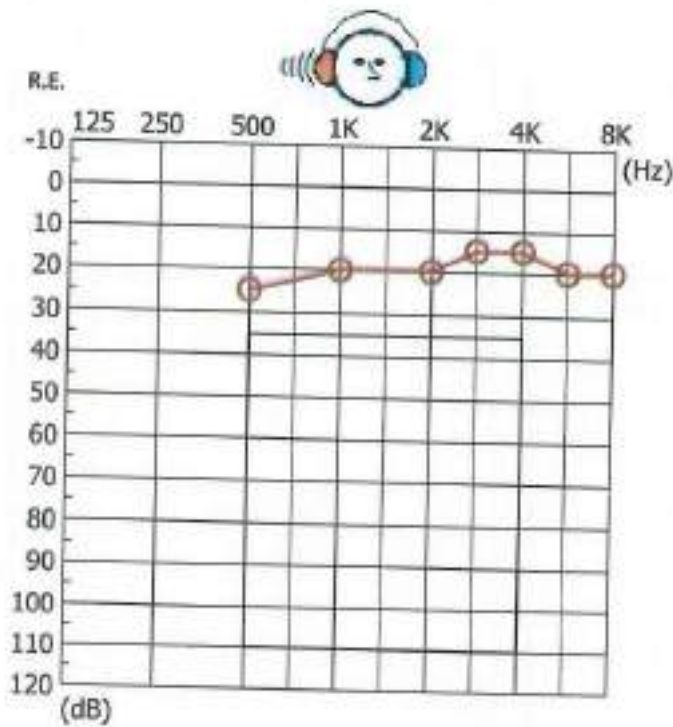
UU  
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## AUDIOMETRY REPORT

Name: HUSSAIN, MUZAMMAL  
Age(y): 45  
Sex: Man  
Height (cm): 0  
Weight(Kg): 0  
BMI:

## SIBELMED W50

Test date: 30/10/2025  
Reference: 108911556  
Technician:  
Reason:  
Origin:  
Equipment:  
Device serial numb.:  
Flash Version:



### MINISTRY OF LABOUR AND SOCIAL AFFAIRS

|                    | R.E. | L.E. |
|--------------------|------|------|
| Hearing Loss (%)   | 0.0  | 0.0  |
| Average dBs        | 20.0 | 20.0 |
| Bilateral Loss (%) | 0.0  |      |

Right ear: Normal  
Left ear: Normal

COMMENTS: Normal

| No Masking  | R.E. | L.E. | With Masking | R.E. | L.E. |
|-------------|------|------|--------------|------|------|
| Air         | O    | X    | Air          | △    | □    |
| Bone        | <    | >    | Bone         | =    | =    |
| F.Field     | ⊗    | ⊗    |              |      |      |
| No response | ⊗    | ⊗    |              |      |      |

DR. HAMMAD MD ISMAIL  
GENERAL PRACTITIONER  
MOH License No: 20978



| Patient Id | Patient Name      | Age/Sex | Procedure Date | Referring Dr |
|------------|-------------------|---------|----------------|--------------|
| 16088      | MUZAMMAL HUSSAIN. | 45Y/M   | 30-10-2025     |              |

**DIGITAL X-RAY CHEST PA VIEW****FINDINGS:**

Trachea and mediastinum in midline.

Both lung fields show normal bronchovascular markings.

Cardiothoracic ratio is within normal limits.

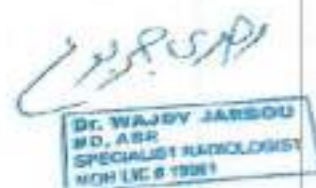
Both cardiophrenic and costophrenic angles are free.

Both domes of diaphragm are normally placed.

Bony ribcage and soft tissue structures appear normal.

**IMPRESSION:**

- NO ABNORMALITIES DETECTED



Dr. Wajdy Jarbou  
MD ABR  
Specialist Radiologist  
MOH Lic # 19061

|                           |                        |
|---------------------------|------------------------|
| NAME: MUZAMMAL HUSSAIN    | AGE: 45 Years          |
| DATE OF ISSUE: 13/12/2025 | FILE NO: 14460716      |
| GENDER: MALE              | NATIONALITY: PAKISTANI |

### MEDICAL REPORT

Mr. Muzammil hassain , a 45-year-old gentleman, was seen and examined by me on 13/12/2025. He was detected to have mixed Hyperlipidemia OQ Medical Check-up. He was asymptomatic during this medical examination.

**Past Medical History:**

1., Dyslipidemia - 1 year

**Physical Examination:**

**Physical Examination:**  
Vital Signs: Pulse: 60/nt Regular. BP: 112/78 mmHg. Temperature: 36.8 degrees Celsius.  
Respiratory Rate: 18/minute, SpO2: 98%. Height: 175 cm, Weight: 88 Kg.  
Clinical examination of Respiratory, Cardiovascular, Gastrointestinal and Central Nervous System is Normal.

**Investigations:** 1. Total Cholesterol 381 mg/dl 2. Triglyceride 487 mg/dl 3. LDL- CHOL 202 mg/dl

### Diagnosis:

### 1. E78.2 - Mixed Hyperlipidemia

**Prescription:**

1. ROSUVAS TAB 10mg(Rosuvastatin)30's Pack (Tablet) 0-0-1 (1 Tablet) (Oral)  
2. MEGA-[3]-ACID ETHYL ESTERS 1 g soft capsule(OmAcor 28's) (Tablet) 0-0-1 (1 Capsule) (Oral)

### Adviser:

1. Continue taking medicines regularly.
2. Diet
3. Exercise.
4. Regular follow ups.

\*\*\*HE IS FIT FOR WORK\*\*\*

Dr. Rajeev,

Internal Medicine Specialist  
Ghoubra

**Specialist**