

# MEDICAL EVALUATION REPORT FOR OQ CONTRACTORS - SUMMARY



CANDIDATE / EMPLOYEE IDENTIFICATION							
Civil ID / Passport #	Company ID #	16113 Reg.Dt 25/10/2022 Name NARINDERJIT SINGH			Position		
Nationality	Age	Sex	Length	Reg.Dt	25/10/2022		
					Location		
EXAMINATION TYPE							
Examination	<input checked="" type="checkbox"/> Pre-employment		<input type="checkbox"/> Periodic		<input type="checkbox"/> Exit		
VITAL SIGNS & BODY MEASURES							
Blood Pressure Category:	120/70 <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Prehypertension <input type="checkbox"/> Hypertension Stage 1 <input type="checkbox"/> Hypertension Stage 2 <input type="checkbox"/> Hypertension Crises						
BMI Category:	26.12 <input type="checkbox"/> Underweight <input type="checkbox"/> Normal <input type="checkbox"/> Overweight <input type="checkbox"/> Obese <input type="checkbox"/> 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	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal		
Pre-existing condition:							
Remarks:							
RESPIRATORY SYSTEM							
Spirometry Test	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required	Chest X-Ray	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required
Pre-existing condition:							
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:							
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	
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 checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required	
Pre-existing condition:							
Remarks:							
LABORATORY INVESTIGATIONS							
Lab Tests:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, please specify below:				
Pre-existing condition:							
Remarks:							
Glucose Level Category							
Cholesterol Risk Category	91	<input checked="" type="checkbox"/> Normal 80 – 100 mg/dl	<input type="checkbox"/> Pre diabetic 100 – 125 mg/dl	<input type="checkbox"/> Diabetic > 126 mg/dl			
Routine Urine Analysis	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required	Stool Analysis	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> 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 negative	<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 16)	<input type="checkbox"/> Positive answers Factor IV (17 to 20)					
Clinic Doctor Name	License # 33, Series No. 141234567890	Hospital/Policlinic	Doctor Signature & Clinic Stamp		Issue Date		
Abubaker A-Halim					31-10-2022		
OO - Occupational Health Department							
Dr. ABUBAKER A-HALIM MOHAMED KHEIR IBRAHIM MOH License No: 20974							
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PEACE MEDICAL & DENTAL CLINIC PO BOX: 141234567890 1111 VAT NO: 2217783 C.R.NO: 2217783							
Tutor Review - 02-30/05/2021							

# FITNESS TO WORK CERTIFICATE - OQ CONTRACTORS



EMPLOYEE IDENTIFICATION					
Civil ID / Passport #	Company ID #				Position
		Ent	18113	Reg.Dt	25/10/2022
Nationality	Age	Sex	Name: NARINDERJIT SINGH		
EXAMINATION TYPE					
<input checked="" type="checkbox"/> Pre-employment Examination (PRE) <input type="checkbox"/> Change of Position Examination <input type="checkbox"/> Emergency Response Team		<input type="checkbox"/> Periodic Medical Examination (PME) <input type="checkbox"/> Exit Examination <input type="checkbox"/> Travelling Examination		<input type="checkbox"/> Post-absence Examination <input type="checkbox"/> Critical Activities Examination <input type="checkbox"/> Medical Surveillance	
Medical Suitability for Work					
Medical Suitability for Work	<input checked="" type="checkbox"/> Fit to work <input type="checkbox"/> Fit with following restrictions <input type="checkbox"/> Pending Fitness <input type="checkbox"/> Not fit to work				
Restrictions					
<input type="checkbox"/> Working at height <input type="checkbox"/> Working in confined space <input type="checkbox"/> Working with electricity <input type="checkbox"/> Working near rotating machinery <input type="checkbox"/> Working in noise area <input type="checkbox"/> Working in extreme heat <input type="checkbox"/> Handling chemical products <input type="checkbox"/> Use of respirator			<input type="checkbox"/> Pulling, pushing or carrying weight <input type="checkbox"/> Ascend/descend ladders and stairs <input type="checkbox"/> Walking or standing for long distance/period <input type="checkbox"/> Repetitive movements <input type="checkbox"/> Mobile machinery operation <input type="checkbox"/> Heavy lifting operation <input type="checkbox"/> Driving vehicle <input type="checkbox"/> Emergency response duty		
Other, specify					
New Position		New Function		New Department	
NA		NA		NA	
Examination Date		Exams Performed			
25-10-2022					
Medical Review Date				Employee Signature	
Doctor Name ATRURAN - A. HANNA		Medical License No.  Dr. ABUBAKER ABDELHALIM MOHAMED KHEIR IBRAHIM MOH License No. 20074		Medical Doctor Signature	
OQ - Occupational Health Department Form Review - 02-30/05/2021					