FORM C – OFFSHORE AND REMOTE ONSHORE MEDICAL ASSESSMENT FORM

SECTION 1 – TO BE COMPLETED BY EMPLOYEE (PERSONAL INFORMATION, HEALTH DECLARATION AND CONSENT)

A. Worker Details

Name _____ **NRIC / Passport** _____

Company & Address _____ **Age** _____

_____ **Occupation** _____

_____ **Race** _____

Date of examination _____

Place of examination _____ **Sex** **Male** ☐ **Female** ☐

Name & Address of personal physician _____

_____

List your last 3 jobs **1.** _____ **2.** _____ **3.** _____

B. Type of examination ☐ **Initial/Renewal** ☐ **Return to work**

C. Type of Evaluation for Offshore & Remote Onshore (As per Employer Letter/Instruction)

- ☐ G General work (*Other than Job Specific*)
- ☐ S1 Catering Crew
- ☐ S2 Confined Space Worker
- ☐ S3 Crane Operators
- ☐ S4 Electrical Worker
- ☐ S5 Emergency Response Team (ERT)
- ☐ S6 Respirator Protective Equipment User
- ☐ S7 Working at Height
- ☐ V1 Visitor

DO YOU HAVE OR HAVE YOU HAD : (Tick 'Yes' or 'No')

Note: MPM AME shall enter the FTW Status into MPM E-Reporting System (MySDS) and retained a record for future reference.

Description	Y	N	Description	Y	N	Description	Y	N
1.Sinus trouble			22.Cancer			**Have you ever been:-**		
2.Neck swelling / gland			23.Heart disease			43.Rejected for employment or insurance		
3.Difficulty in vision			24.Rheumatic fever			44.Awarded benefits for Industrial injury/ illness		
4.Any ear discharge			25.Abnormal heartbeat			45.Treated for problem of mental condition		
5.Bronchial Asthma / Bronchitis			26.High blood pressure			46.Treated for problem of alcohol or drug		
6.Hay fever / Other allergy			27.Stroke			47.Exposed to toxic substances or noise		
7.Any skin trouble			28.Serious chest pain			**WOMAN ONLY, Have you ever had:-**		
8.Tuberculosis			29.Any blood disease			48.Abnormal Pap smear		
9.Coughed / Vomited blood			30.Painful passage of urine			49.Any gynecological condition / treatment		
10.Severe abdominal pain			31.Blood in urine			50.Are you pregnant		
11.Stomach Ulcer			32.Diabetes			**Will you be doing any of these specific activities;**		
12.Recurrent indigestion			33.Headache / Migraine			51.Crane Operators		
13.Jaundice or hepatitis			34.Dizziness / fainting			52.Users of Breathing Apparatus		
14.Gall Bladder disease			35.Epilepsy			53.Catering Crew		
15.Marked change in bowel habits			36.Joint/spinal trouble			54.Confine Space Entry		
16.Blood in stools (motions)			37.Surgical operation			55.Working at Height		
17.Dental Problem			38.Serious accident / injury			**Social History**		
18.Piles (Haemorroid)			39.Tropical disease			56.Do you smoke?		
19.Hernia			40.Fear of heights			57. History of drug abuse		
20.Varicose Veins			41. Fear of being enclosed in a small space			58.Do you drink alcohol? If yes, amount per week?		
21.Lump in breast / arm pit			42. Are you currently taking Any medication?			59. Have you been medical disembarked from offshore within the past 2 years? If yes, please specify:		
						60. Other illness not mentioned above. If yes, please specify:		
Have any of your family members suffered from the following?								
61.Diabetes			64.Heart Disease			67.Hypertension		
62.Tuberculosis			65.Epilepsy			68.Stroke		
63.Bronchial Asthma			66.Cancer			69.Blood Disease		

I hereby certify that the above information is correct to the best of my knowledge. I understand that voluntary non-disclosure of any information required above is a breach of PETRONAS fitness to work requirements and may result in disciplinary action against me. I further agree to give consent to the examining medical professionals to disclose the results of this medical questionnaire and associated medical examination details to PETRONAS, Petroleum Arrangement Contractor (PAC) and my Employer for managing all matters related to my Fitness to Work Offshore and/or Remote Onshore Worksite.

Signature:

Name

Date:

SECTION 2 – FOR USE BY EXAMINING DOCTOR

Note: MPM AME shall enter the FTW Status into MPM E-Reporting System (MySDS) and retained a record for future reference.

HEIGHT (Meter)	WEIGHT (Kilogram)	BMI (Kg/m²)	BLOOD PRESSURE	PULSE	VISION	Distant		Near		COLOUR VISION	BLOOD GROUP
					Corrected						
					Uncorrected						

N	A	DESCRIPTION	MEDICAL EXAMINATION – Detail of findings
		1. Eyes & Pupils	
		2. Ear/Nose/Throat	
		3. Teeth & Gum	
		4. Mouth	
		5. Respiratory	
		6. Cardiovascular System	
		7. Abdomen	
		8. Hernial Orifices	
		9. Extremities	
		10. Musculo-skeletal	
		11. Skin & Varicose Veins	
		12. Neurological	
		13. Breasts	
		14. Anus & Rectum	
		15. Genito-Urinary Systems	
		16. Others	

N	A	TEST	INVESTIGATION FINDINGS
		1. Complete Blood Count	
		2. BUSE	
		3. Serum Creatinine	
		4. Fasting Serum Lipid	
		5 Fasting Blood Sugar (HBA1c if indicated)	
		6. Urinalysis	
		▪ Urine Drugs a. Amphetamine b. Benzodiazepines c. Cannabis d. MDMA e. Opiates f. Cocaine	
		8. Audiometry	
		9. Chest X-ray	
		10. ECG (40 years and above or clinically indicated	
		11. Spirometry (if clinically indicated)	
		12. Others	

N = Normal A = Abnormal

Note: MPM AME shall enter the FTW Status into MPM E-Reporting System (MySDS) and retained a record for future reference.

APPENDIX B1 – OFFSHORE & REMOTE ONSHORE MEDICAL FITNESS CERTIFICATE

To: …….. (Employer)

Section A: Personnel Data			
Last Name:	First Name:		DOB:
ID No:	Tel No:	Occupation:	
Date:		Company:	

Section B: Type of Examination	☐ Initial/Renewal	☐ Return To Work

Section C: Type of Evaluation

☐ G General Offshore work (*Other than Job Specific*)

☐ S1 Catering Crew
☐ S2 Confined Space Worker
☐ S3 Crane Operators
☐ S4 Electrical Worker
☐ S5 Emergency Response Team (ERT)
☐ S6 Respirator Protective Equipment User
☐ S7 Working at Height
☐ V1 Visitor

Section D: Fitness to Work Status

The above personnel have been assessed in accordance to the "Guidelines on Medical Assessment of Fitness to work for Offshore & Remote Onshore Workers" and the fitness to work status for the evaluation listed in Section C is/are as follows.

☐ Fit with no restrictions. Valid until (dd/mm/yy) ……...for 2 years

☐ Fit with following restrictions :-

The employee is fit for above work but should avoid the following tasks:

☐ Work near moving machinery or sharp edges
☐ Working at height
☐ Pull push carry weight over ……kg
☐ Operate motor vehicles or heavy machinery
☐ Use a respirator
☐ Repetitive twisting of valves or wrenches
☐ Others (Specify):

……..

……..

☐ These restrictions are Permanent

☐ These restrictions are Temporary until (dd/mm/yy)…….....

☐ For Validity Restriction Only (dd/mm/yy)……..

☐ Unfit due to following reasons:

☐ Not fulfil FTW standards
☐ MRO positive result
☐ Incomplete medical assessment
☐ Refusal of urine drug test

Section E: Approved Medical Examiner's Details

Name:	Signature:	AME Stamp:
Address:		
Tel:	Date:	

NOTE: MPM AME shall enter the FTW status into MPM e-reporting system (MySDS) and retained a record for future reference.