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In line with the principles and objectives of the National Occupational Safety and Health Policy issued by Cabinet Decision No. 328 dated 13/06/1442 AH, aimed at assessing and preventing hazards to reduce occupational injuries and diseases through the development of legislation, regulations, technical guidelines, programs, and any applicable organizational tools, and based on the powers and responsibilities of the National Council for Occupational Safety and Health as outlined in Article (3) of the Council's regulation issued by Cabinet Decision No. 379 dated 07/07/1443 AH, and in accordance with the amended Labor Law under Royal Decree No. (M/5) dated 07/01/1442 AH, labor laws are fundamental in defining and regulating the relationship between workers and employers to protect rights.

In line with what is stated in the law in Article 131 (repeated), Article 143, and Article 187 of the Labor Law regarding the mandatory medical examinations, this regulation has been prepared in cooperation with government agencies and in consultation with representatives of employers and workers, applying the best local and international standards and practices for medical fitness examinations in accordance with the requirements of the International Labor Organization and the World Health Organization, to clarify the mechanisms related to medical fitness examinations for all professions in the Saudi labor market. This aims to monitor and follow up on individuals' health to enhance occupational health through pre-placement and periodic examinations for workers, thereby contributing to reducing workplace accidents and occupational diseases and improving working environments in the Kingdom of Saudi Arabia.

Article One

Regulation	Occupational Fitness & Non-communicable Diseases Examinations Regulation.
Council	The National Council for Occupational Safety and Health.
Minister	The Minister of Human Resources and Social Development.
First Official	The Minister, the Governor or Chief Executive Officer, the Chief Executive, the Supervising Secretary, or their representatives.
Employer	Any natural or legal person who employs one or more workers for a wage or whoever he authorizes in private sector establishments.
Worker	Any natural person, male or female, who works for an employer and under his management or supervision in return for a wage, even if he is away from his sights.
Employee	Any person who occupies a public civil office in the State or exercises its functions, regardless of the nature of his work or the name of his job, whether by appointment or contracting permanently or temporarily.
Establishment	Any project managed by a natural or legal person employing one or more workers in return for remuneration of any kind.
Professional fitness	It is the ability of the individual, physically, mentally, and psychologically, to perform the job or professional tasks assigned to him without resulting in harm to his health or danger to the safety of others or the surrounding environment, and this is determined based on an approved medical evaluation conducted by an entity specified in this regulation.
Occupational Safety and Health	Protecting the worker/employee from any hazard related to his work that poses a threat to his safety or health, including physical, mental, and social health.
Follow-up of occupational fitness	Determining changes in health status as a result of practicing activities and tasks that lead to exposure to certain substances at the work site, through a doctor specializing in occupational medicine.
Occupational medical examination	research surveys and clinical examination for the purpose of preventing occupational diseases.
Occupational Medicine	It is the doctor specialized in occupational medicine specialist/consultant, classified by the Saudi Commission for Health Specialties, and it is a branch of medicine concerned with the health and safety of workers in the workplace, and aims to prevent, diagnose and treat diseases and injuries associated with the profession.
Occupational disease	A disease that arises due to work in professions or economic activities that cause this disease and is not due to factors external to its work, provided that this disease is included in the schedule of occupational diseases in which these diseases are exclusively specified.
Non-communicable diseases	Also known as chronic diseases, are conditions that tend to be of long duration and result from a combination of genetic, physiological, environmental, and behavioral factors. The main types of NCDs include cardiovascular diseases (such as heart attacks and strokes), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma), and diabetes.
Profession	It is a work or job performed by an individual on a regular basis, and requires specialized skills and knowledge acquired through education or training and aims to provide a specific service or work in exchange for a wage or income.
Entity	Any ministry, government agency, authority, department, public institution, fund or the like, and any independent body with a public legal personality.
Competent Authority	Any entity involved in the implementation of the provisions of this Regulation or the related laws, regulations, and decisions.
High-Risk professions and environment	Occupations whose workers may be exposed, permanently or partially, depending on the duration of exposure and frequencies, when performing work tasks, to high-risk activities and operations - for example, but not limited to, construction sites, working in transportation services, or handling high-risk materials such as chemicals or ionizing radiation, which increases the likelihood of occupational disease or accidents that may cause death or result in serious injury or disability.
Hazardous occupations	They are those that increase the risk of injury or death of the worker due to working conditions, such as working in mines or at high altitudes or when exposed to multiple physical, chemical or biological hazards determined by the risk assessment.
Restricted Occupations	They are those that impose restrictions on the worker determined by law (statutory) and include periodic examinations due to impact on the worker's health and safety or others in the workplace, or in public places or the surrounding environment, such as aviation, public transport, work in food handling and processing, seafarers, firefighters and others.
Preventive measures	All preventive measures that are implemented to reduce the expected risks and losses.
Long medical leave	The absence of the employee/worker from work for health reasons that prevent him from performing his job duties for a period exceeding eight consecutive weeks.
Hierarchy of control	It is a systematic framework adopted in occupational safety and health systems and is used to reduce exposure to risks in a hierarchy that begins with the most effective measures, which are removal, replacement, then engineering controls, then administrative controls, and finally personal protective tools.

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Article Two:

This regulation aims to provide a comprehensive framework for assessing the health and psychological fitness of employees/workers to ensure that they are able to perform their job duties efficiently and safely in line with national standards and best international practices, which are the following:

1- Reduction of work injuries and accidents and occupational diseases.

2- Enhance the physical and psychological fitness of employees/employees.

3- Ensure that employees/employees are able to perform their tasks safely and efficiently

4- Introducing the mechanism of pre-appointment/employment medical examinations and periodicity for high-risk practitioners.

5-Unify pre-appointment/employment medical examination forms, periodic examination and exceptional examination that suit each profession and provide comprehensive databases on the health status of all employees/employees.

6- Improve compliance with local standards and regulations and international conventions in the field of occupational safety and health.

Article Three:

1- The provisions of this regulation shall apply to all employees in public entities, private sector establishments, and non-profit organizations, regardless of the type of contractual relationship or the nature of work, and include permanent employees, temporary or seasonal contract workers, trainees, people with disabilities, and workers under the remote work system, in any of the following cases:

A- Before the start of the employment relationship when applying for employment, and it is required to pass the medical examination of occupational fitness before completing the appointment.

B- Employees on the job in the following cases:

- After an occupational injury
- Upon return from a long medical leave
- When there are doubts about the ability of the worker / employee to perform his work
- If the job / profession requires a periodic medical examination in accordance with the approved forms attached to this regulation.
- Upon a change of occupation, if the worker/employee is transferred to a position or occupation that requires a different type of medical examination, additional tests shall be conducted in accordance with the approved examination forms set out in the Appendix to this Regulation.
- In the event of a change in the work environment, including but not limited to the permanent or temporary assignment of the worker.
- If new equipment, machines or devices are used.

C- Upon retirement from work in case of exposure to materials with a long latency period during the period of work, such as asbestos or ionizing radiation.

2- The application of this regulation does not apply to medical examinations outside the scope of the job/profession.

Article Four:

The first official in government agencies / civil public sector and the employer in private and non-profit sector establishments (or their delegates) shall comply with the following:

1- Verifying and ensuring that occupational fitness examinations are conducted and following up on his employees according to the approved forms and professions specified for them and making the necessary arrangements to enable the worker / employee to do so.

2- Provide the necessary resources to conduct examinations for its employees.

3- Notify the doctor specialized in occupational medicine of any exposures or risks that may affect the safety and health of the worker/employee during the practice of work, and the employer must refer the worker/employee to the competent doctor to ensure his health fitness.

4- Ensure that the worker receives appropriate health monitoring of health and safety risks to which he is exposed at work.

5- Work on creating health records within the standards of the Personal Data Protection System that include various documents containing the professional medical history of the worker/employee in his workplace, assessing risks and exposures in the workplace, and sharing them with relevant parties through the means approved by the Board.

6- Support compliance with the provisions of the Regulation.

7- Take all procedures and measures to organize work in accordance with the requirements of the regulation.

8- Do what is necessary to find alternative work if the worker's job is medically prohibited, considering the following cases:

A- In the event of changes in the employee's health status or a new development in medical restrictions, the employer must reconsider the alternative work provided and update it in proportion to the health status to ensure the employee's success in the new job while maintaining his health and safety.

B- If the worker/employee is unable to fully perform alternative work tasks due to medical restrictions, the employer must provide the necessary adjustments to the working conditions, such as flexible working hours, part-time or any other arrangements to ensure that the employee continues in a safe and appropriate environment.

C- If an employee's health condition improves over time and they are able to return to their original employment, the employer must conduct a comprehensive assessment that includes a fitness check to restore the employee's original job in line with their current health condition.

Article Five:

Employees and employees are committed to the following:

1- Undergo the occupational fitness examinations required by the employer, in accordance with the requirements of this regulation, the approved forms, the nature of the profession under assignment, and in coordination with the concerned authority within the establishment.

2- Disclosure of occupational symptoms, injuries and diseases and providing any necessary health information according to the approved form.

3- Immediately notify the employer or his representative of any risks, defects or practices that may affect his safety or the safety of those around him within the work environment.

4- Inform the competent authorities of any fundamental violations committed by the establishment related to non-implementation of the requirements of this regulation, whenever this is proven to the worker and affects occupational safety and health.

Article Six:

Any employee or worker may submit a report to the competent authorities regarding any violations committed by the entity or establishment related to the non-implementation of the requirements of this Regulation.

Article Seven:

The occupational fitness examination form for the worker/employee is selected according to the following criteria:

1- Actual work.

2- Job description.

3- The physical, chemical, or biological substances hazards to which they are exposed.

4- The mechanism of exposure.

5- The level of exposure to physical, chemical, or biological substances or factors.

6- Duration of exposure to physical, chemical, or biological substances or factors.

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7- Applying preventive measures and providing special equipment conforming to the standard specifications issued by the Saudi Standards, Metrology and Quality Organization regarding occupational safety and health to reduce exposure to materials in accordance with the relevant regulations and monitor adverse health effects.

Article Eight:

The occupational fitness examination may not be used as a substitute for the implementation of individual or collective hierarchy of controls, and it is prohibited to rely on it as the sole basis for protecting the worker, except for the following cases:

1- Use the results of the examination to assess the effectiveness of control measures applied to practitioners, by measuring occupational exposure levels.

2- Use the results of the examination to support the decision to apply new or more effective preventive measures, whenever necessary, and the employer remains responsible for ensuring a safe working environment, regardless of the results of occupational fitness examinations. In all cases, the principle of gradual risk control shall be applied, so that engineering and administrative measures, isolation and ventilation techniques, and protective equipment are provided over medical or control means, considering medical examination as a means of monitoring, not prevention.

Article Nine:

The types of medical examinations for occupational fitness are as follows:

1- Completion of the questionnaire attached to the regulation by the worker or employee.

2- Medical history by the doctor-in-charge.

3- General medical examination:

A- Vital Signs Assessment.

B- Clinical examination.

C- Examination of sensory functions.

4- Laboratory and radiological tests.

5- Additional specialized examination according to the nature of the profession, according to the approved forms.

Article Ten:

The mechanism for carrying out the tests shall be as follows:

1- Pre-appointment/employment medical examination: This examination is conducted on all candidates for jobs/professions and includes the analysis of medical history and history of exposure to occupational conditions, according to the approved forms according to the nature of the profession / job.

2- Periodic medical examination: Conducted at regular intervals according to the requirements of each profession/job, and the type and level of potential health risks, these periodic check-ups may be legally "restricted" such as working in aviation, diving, manufacturing and servicing food, firefighting, carrying weapons, handling explosives, radioactive materials, etc.

3- Exceptional medical examination: It is conducted when needed, such as an accident or a noticeable change in performance, or if the specialist doctor notices early signs of specific occupational diseases or the presence of a group of similar cases resulting from possible exposure to occupational hazards or exposure to toxic substances, or suspicion of using prohibited and narcotic substances, and the specialist doctor must ensure that the occupational injury or occupational disease is reported in the competent authority.

Article Eleven:

The occupational periodic fitness medical examination consists of four integrated programs as follows:

1- Mandatory initial examinations: These are periodic basic examinations required for all workers in specific professions according to licensing and practice regulations, including:

A- Compulsory Professional Fitness Questionnaire.

B- Vital signs assessment.

C- Clinical examination.

D- Examination of the senses.

E- Laboratory and radiological tests.

The results of these examinations are part of the legally binding occupational health record.

2- Mandatory advanced examinations: determined based on the risk assessment or conditions of the working environments or added by the occupational medicine specialist based on other health indicators, including:

A- Spirometry and respiratory fit testing.

B- Aerobic fitness tests (oxygen-based exercises) depending on the nature of the tasks.

C- Substance use testing.

D- Job-mandated tests (e.g. tests related to infectious diseases).

3- Occupational fitness examinations according to exposure: The establishment must add examinations according to exposure to work hazards, such as chemical, physical or biological, to the list of examinations required for the profession and update this in its internal policy, in a way that does not contradict the list of compulsory and special examinations.

4- Optional advanced examinations: The supervising or licensed authority for the economic field, the first official or the employer may develop a special policy related to examinations and tests that are commensurate with the nature of work in the profession within the facility, including additional age-related preventive examinations such as glaucoma screening or those related to sex such as screening for breast, cervical or colon cancer in women, prostate or colon in men, or Substance use testing or behavioral assessments, in a manner that does not conflict with this regulation or the relevant national regulations, legislation, policies and regulations.

The color-coded for the test levels is as follows:

(Blue) Occupational fitness examination according to exposure	(green) Mandatory advanced examinations	(Orange) Mandatory initial examinations

Article Twelve:

Occupational fitness examinations for workers in high-risk professions shall be conducted in accordance with the requirements specified in the procedural manual for the organization of work in high-risk professions, and these examinations are divided into the following categories:

1- Medical examination of occupational fitness for hazardous professions.

2- Medical examination of occupational fitness for restricted professions.

Medical examinations of occupational fitness included in the occupational fitness examination forms for high-risk professionals are subject to the color coding of the examination levels as described in the fourth paragraph of Article Eleven.

Article Thirteen:

The results of the tests are dealt with according to the following:

1- Upon completion of the medical examination prior to appointment/employment, the result shall be as follows:

A- "Fit to work" allowed to perform the profession / job for which he is nominated.

B- "Fit to work with restrictions or considerations" required to be adhered to when practicing the profession for which the candidate is nominated, including the duration.

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C- "Unfit to work" not allowed to practice the profession / job for which he is nominated (the duration of the time is determined by the professional doctor).

2- In the event that the requirements of professional fitness are not met after the periodic examination, the worker/employee is prevented from continuing to practice his profession and the supervising department must take the necessary measures to modify/change his profession, unless there is sufficient evidence proving his ability to perform his job duties efficiently and without risks to himself or others, through additional examinations or recommendations determined by occupational medicine specialist, and the employer has the right to exclude some cases, provided that the safety and health of the worker / employee is not affected after the approval of the committee and the worker.

3- In case of objection, the worker/employee or employer has the right to request another evaluation from an independent medical examiner.

Article Fourteen:

1- The employer shall be obliged to inform the worker of the result of the fitness assessment immediately upon receiving the result from the service provider.

2- The worker or candidate for the job has the right to object to the result of the occupational fitness examination, of any kind, within a period not exceeding thirty (30) days from the date of official notification of the result.

3- Objections shall be referred to an independent committee formed in the secretariat of the Council, which shall review the medical file, examinations, and relevant technical reports. The Committee may request additional examinations or an impartial medical opinion from an independent professional examiner.

4- The Committee shall issue its decision within a period not exceeding fifteen (15) days from the date of receipt of the objection.

5- The decisions of the Committee shall be binding on the concerned authorities unless challenged before the competent authorities by law, and this shall not prejudice the worker's right to resort to the competent judicial authorities in accordance with the relevant regulations.

Article Fifteen:

The medical examination of occupational fitness must be conducted by a specialized team under the supervision of an occupational medicine specialist doctor accredited by the Saudi Commission for Health Specialties.

Article Sixteen:

The team and the doctor specialized in occupational medicine are obligated to conduct medical examinations before appointment / employment, periodic examinations, and exceptional examinations for employees and employees, in accordance with the approved occupational fitness examination forms attached to the regulation. The standards specified in the forms must be adhered to and not modified or exceeded except after the approval of the secretariat of the National Council for Occupational Safety and Health.

Article Seventeen:

1- Professional health records are confidential documents and may only be viewed by health care professionals in the facility or by the authorities concerned with conducting medical examinations, within the limits required by their duties, and in accordance with the provisions of the Personal Data Protection Law.

2- The medical records of employees/employees may be transferred when moving to another facility after obtaining written or electronic approval from them.

3- Strict procedures and measures shall be adopted to ensure the security and protection of information and technology to prevent loss, misuse, modification, or unauthorized access to the electronic system, in accordance with the controls of the National Data Governance Policy and the relevant regulations issued by the Saudi Authority for Data and Artificial Intelligence.

4- The employer is prohibited from accessing any medical details, and is limited only to knowing the final occupational decision regarding the worker's ability to work, which includes:

A- Fit.

B- Fit with restrictions or considerations.

C- Unfit.

With a statement of restrictions or professional considerations, if any, without disclosing the diagnosis or private medical data.

5- The doctor specialized in occupational medicine is responsible for documenting the results of occupational fitness examinations accurately and objectively and recording them in the worker's approved occupational health record, in accordance with the forms and procedures specified in this regulation, while adhering to the provisions of the Personal Data Protection and Health Privacy Law.

6- The records shall include all medical observations, entries, and recommendations, signed, dated and completed by the competent doctor, and kept in the worker's file with the concerned authority, with a copy of them provided to the Secretariat of the National Council for Occupational Safety and Health when needed.

7- The entity keeping the medical records shall keep the occupational health record for a period of not less than ten (10) years from the date of the last examination, or for a period of five (5) years after the termination of the employment relationship, whichever is longer. In the event that the worker has been exposed during his period of employment to substances or agents with a long latency period or delayed health effects, such as asbestos or ionizing radiation, the register must be kept for a period of not less than thirty (30) years after the cessation of work and until the worker reaches the age of seventy-five, in accordance with NRRC-R-01 Rev. 0.1, 2024, section 166.C, and the approved international standards.

Article Eighteen:

1- This regulation shall apply to all employees within the territory of the Kingdom of Saudi Arabia, including employees of government agencies, private sector establishments, or non-profit organizations, including workers in diplomatic and consular missions and official offices of the Kingdom abroad.

2- The provisions of these Regulations shall not apply to workers who practice their work outside the Kingdom for Saudi establishments, unless the employment contract expressly stipulates that they are subject to them.

3- If the employment contract includes a provision that the worker is subject to the provisions of these Regulations while practicing his work outside the Kingdom, this shall not conflict with the regulations in force in the country in which the worker practices his work.

4- The Saudi establishment shall, in the cases provided for in paragraph (3), verify the legality of the application of the provisions of the Regulations in the host State, and shall take all possible measures to adapt the implementation of medical examinations and occupational health measures to achieve the preventive purpose, without violating local laws or prejudice to the rights of the worker.

Article Nineteen:

In the event of a violation of the provisions of this regulation, the penalties and sanctions stipulated in the relevant laws, regulations, and decisions within the supervisory scope of the competent authorities shall be applied.

Article Twenty:

The Council shall issue the regulatory rules, provisions, and guidelines related to these Regulations.

Article Twenty-One:

The Council may issue guidelines, decisions, regulatory rules, and provisions related to the implementation of thes

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المرفق ١:

نموذج الفحوصات الطبية العامة يشمل جميع المهن بخلاف الفئة المهنية التي تتطلب نماذج خاصة وفحوصات إضافية

(GENERRAL MEDICAL SHEET).

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information			
Job Code:			**Job Title:** **Date of joining current job:**
Name in full (last, first, middle):		**National ID:** **Iqama No**	**Employment:** ☐ New hire ☐ Rehire
Date of birth:	**Gender:** ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married (IF Yes) ☐ Pregnant (If applicable) ☐ Yes ☐ No	
Address & telephone No.		**Email address:**	

Health Questionnaire		
Do you currently have or previously had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.	☐ Yes	☐ No
2- Chest problems (asthma, difficulty breathing, chest tightness, coughing or others)	☐ Yes	☐ No
3- Any neurological disorder e.g. (severe/frequent headaches, unsteadiness, stroke, transient ischemic attacks, tremors, sleep disorder, paralysis) or others	☐ Yes	☐ No
4- Epilepsy, Convulsions or loss of consciousness	☐ Yes	☐ No
5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/ dislocations)	☐ Yes	☐ No
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)	☐ Yes	☐ No
7- Any Eye/vision problem or color blindness	☐ Yes	☐ No
8- Thyroid or other endocrine problem	☐ Yes	☐ No
9- Diabetes	☐ Yes	☐ No
10- Ear, nose, throat, hearing difficulties, tinnitus, or motion sickness requiring medication	☐ Yes	☐ No
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others	☐ Yes	☐ No
12- Urinary problem (Kidney, Bladder or Prostate)	☐ Yes	☐ No
13- Skin problem (e.g. allergies or dermatitis)	☐ Yes	☐ No
14- Infectious/contagious diseases	☐ Yes	☐ No
15- Tuberculosis	☐ Yes	☐ No
16- Digestive problem	☐ Yes	☐ No
17- Sleeping Disorders (OSA or Day Time Sleepiness)	☐ Yes	☐ No
18- Significant injuries	☐ Yes	☐ No
19- Cancer	☐ Yes	☐ No
20- Have you ever had any surgeries?	☐ Yes	☐ No
21- Have you ever been hospitalized?	☐ Yes	☐ No

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22- Suicide attempt	☐ Yes	☐ No
23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)	☐ Yes	☐ No
24- Any health problem, which requires visits to the doctor, or for which you take regular drugs for? **If any of the above questions were answered "yes", please give details by referencing the item number.** **Provide information regarding diagnosis and treatment, including dates of treatment.**	☐ Yes	☐ No
Occupational History:		
25- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? **IF YES,** **Industry: ----------** **Job title: ----------** **Employer address: ----------** **Dates of employment: ----------** **Type of exposure……** **Duration of exposure……..** **Refer to Occupational Exposure questionnaire**	☐ Yes	☐ No
26- Have you ever received worker's disability benefits/ compensation?	☐ Yes	☐ No
27- Have you been absent from work for medical reasons in the past five years?	☐ Yes	☐ No
28- Have you ever required light or restricted duty? **List type and duration**	☐ Yes	☐ No
29- Have you ever had any occupational illness	☐ Yes	☐ No
If any of the above questions were answered "yes", please give details by referencing item number.		
Do you use:		
Tobacco (Cigarettes, Shisha, pipe, Vape, …….)	☐ Yes	☐ No
Alcohol	☐ Yes	☐ No
Substance	☐ Yes	☐ No
If yes, ☐ **Current use** ☐ **Previous use** **Give details:**		
Were you subjected to medical examinations (within the past 6 months)	☐ Yes	☐ No
If yes, please Specify:		
- Type of assessment: ----------		
- Purpose: ----------		
- Medical facility: ----------		
- Date of examination: ----------		
- Attach results if applicable. :----------		
Vaccination information:		
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA? ☐ **Yes** ☐ **No**		
General:		

Height (cm):	**Weight (Kg):**	**BMI**	**(consider waist- to-hip ratio as best alternative)**

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Pulse rate: _____/min ☐ Regular ☐ Irregular Respiratory rate: _____/min Blood pressure (mm Hg): Systolic: _____ Diastolic: _____			Temperature
Vision: Visual Acuity			
Unaided			Aided
Rt. Eye Distant: /20 Near: /20 Lt. Eye Distant: /20 Near: /20			Rt. Eye Distant: /20 Near: /20 Lt. Eye Distant: /20 Near: /20
(Tick the appropriate)			
Visual field			
Rt. Eye	Normal	Defective	
Lt. Eye	Normal	Defective	
Color vision:	☐ Normal	☐ Defective: Red green/others	
Hearing:			
Whisper test (6 feet):			
RIGHT EAR PASS FAIL			LEFT EAR PASS FAIL
IF IMPAIRED, AUDIOMETRY SHOULD BE DONE			
Physical Findings: (Circle the appropriate)			
General Appearance			☐ Normal ☐ Abnormal
1- Pallor			☐ Normal ☐ Abnormal
2- Edema			☐ Normal ☐ Abnormal
3- Jaundice			☐ Normal ☐ Abnormal
4- Heart (Rhythm, sounds and murmurs)			☐ Normal ☐ Abnormal
5- Cognitive functions			☐ Normal ☐ Abnormal
6- Psychiatric (appearance, behavior, mood, thoughts, communication, and memory)			☐ Normal ☐ Abnormal
7- Mouth/teeth			☐ Normal ☐ Abnormal
8- Ears, nose, throat			☐ Normal ☐ Abnormal
9- Lung and Chest (not including breast exam)			☐ Normal ☐ Abnormal
10- Abdomen (including organomegaly and hernia)			☐ Normal ☐ Abnormal
11- Urinary and genital system (not including pelvic exam)			☐ Normal ☐ Abnormal
12- Upper & lower extremities (strength and range of motion)			☐ Normal ☐ Abnormal
13- Spine			☐ Normal ☐ Abnormal
14- Neurological (Equilibrium, tendon reflexes, coordination, etc.,)			☐ Normal ☐ Abnormal
15- Skin			☐ Normal ☐ Abnormal
Details of abnormality:----------			

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Investigation
- Complete Urine Analysis
- (HbA1C (only if known diabetic or abnormal urinalysis
- Electrocardiogram (ECG) (above the age of 40 years only)
- Chest X-ray Post-Ant view (CXR-PA), (if clinically indicated).
- Audiometry (if clinically indicated or as baseline for applicable jobs)

HEALTHCARE:
- Complete Blood Count (CBC)
- Urine Drug Screening
- Liver and renal function
- HBV, HCV, and HIV screening (If vaccinated against HBV, a HBsAb titer should be performed).
- If vaccinated or has previous natural infection with Measles, Mumps, Rubella or Varicella, a document of the presence of protective serum IgG against those infections is mandatory.
- Interferon-gamma release assay (IGRA)
- Respiratory FIT testing (if needed).

Occupationally Exposed Radiation Workers
- Complete Blood Count (CBC) with differential (baseline)
- Liver and Renal Function Tests (LFTs, RFTs) (baseline)
- Respiratory fit testing (bassline)

MINING AND UNDERGROUND:
- Chest X-ray Post-Ant view (CXR-PA), (baseline).
- Spirometry and respiratory fit testing (baseline)
- Audiometry (baseline)
- Respiratory FIT testing (if needed)

ARMED PERSONNEL:
- Hepatic and Renal function tests
- CBC & Hemoglobin electrophoresis, G6PD (Air Forces pilot and crew only)
- HBV, HCV, and HIV screening
- Spirometry
- Chest x-ray (baseline)
- Audiometry (bassline)
- Drug Screening (Preplacement & Random)

OIL AND GAS:
- CBC and Hemoglobin Electrophoresis
- Audiometry (baseline)
- Spirometry and respiratory fit testing (baseline)

COMMERCIAL DRIVER:
- Audiometry (Baseline) average hearing loss of 0.5,1.0&2.0 kHz in better ear < 40dBA
- Visual field assessment if clinically indicated

FIRE FIGHTER
- Aerobic capacity (minimum MET level of 12)
- Harvard Step Test or Chester treadmill walk test or Bruce protocol or equivalent
- CBC with differential, RBC indices and morphology, and platelet count
- Renal function test
- Fasting blood glucose
- Liver function test
- Lipid profile
- HIV Ab
- Hepatitis C screening + confirmation only if positive baseline and following occupational exposure
- Hepatitis B base line (HBsAg) and vaccination with titers 1-2 months after completion of 3 dose series.
- Tetanus/diphtheria /pertussis (Tdap) vaccine once then Td booster every 10 years
- Document (MMR) or provide two doses according to immunization guidelines.
- Spirometry: annually to measure (FVC), (FEV1), and the absolute FEV1/FVC ratio

AVIATION:
- Comply with the roles set by the General Authority of Civil Aviation (GACA)
regarding civil aviation periodic medical assessments or the Unified Aero-medical Guidelines for G.C.C Armed Forces as applicable.
- Only authorized aviation medical examiners have the authority to issue medical certificates.
- Certificates may be issued, denied, or forwarded to the General Authority of Civil Aviation (GACA) for additional review via the website https://avmed.gaca.gov.sa/md

ELECTRICAL LINE WORKERS:
- Visual assessment including color and depth perception testing
- Urine Drug Screening (pre-placement and random)

Note:
Copies of all investigation reports, X-ray reports, etc. … should be attached to this form as part of the record.

FINAL DECISION OF PRE-PLACEMENT MEDICAL EXAMINATION REPORT

Job title:

Name of the candidate:

Job code:

ID TYPE: (NATIONAL ID) (PASSPORT)

ID NUMBER:

(Attach copy)

Fitness determination:

- FIT
- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:
- FIT with considerations
- FIT with restrictions.
- UNFIT

Name of health professional:

Signature :

Date

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

المرفق ٢: نموذج
(MARINE MEDICAL SHEET)

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information		
Job Code:	Job Title: Date of joining current job:	
Name in full (last, first, middle):	National ID: Iqama No	Employment: ☐ New hire ☐ Rehire
Department (deck/engine/radio/food handling/other): Routine and emergency duties (if known): Type of ship (e.g. container, tanker, passenger): Trade area (e.g. coastal, tropical, worldwide):	Date of birth: Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married (IF Yes) ☐ Pregnant (If applicable) ☐ Yes ☐ No	
Address & telephone No.	Email address:	
Health Questionnaire		
Do you currently have or previously had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.	☐ Yes	☐ No
2- Chest problems (asthma, Difficulty breathing, chest tightness, coughing or others)	☐ Yes	☐ No
3- Any neurological disorder e.g. (Severe/frequent headaches, Unsteadiness, Stroke, transient ischemic attacks, Tremors, sleep disorder, paralysis) or others	☐ Yes	☐ No
4- Epilepsy, Convulsions or loss of consciousness	☐ Yes	☐ No
5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/dislocations)	☐ Yes	☐ No
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)	☐ Yes	☐ No
7- Any Eye/vision problem or color blindness	☐ Yes	☐ No
8- Thyroid or other endocrine problem	☐ Yes	☐ No
9- Diabetes	☐ Yes	☐ No
10- Ear, nose, throat, Hearing difficulties, tinnitus, or Motion sickness requiring medication	☐ Yes	☐ No
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others	☐ Yes	☐ No
12- Urinary problem (Kidney, Bladder or Prostate)	☐ Yes	☐ No
13- Skin problem (e.g. allergies or dermatitis)	☐ Yes	☐ No
14- Infectious/contagious diseases	☐ Yes	☐ No
15- Tuberculosis	☐ Yes	☐ No
16- Digestive problem	☐ Yes	☐ No
17- Sleeping Disorders (OSA or Day Time Sleepiness)	☐ Yes	☐ No
18- Significant injuries	☐ Yes	☐ No
19- Cancer	☐ Yes	☐ No
20- Have you ever had any surgeries?	☐ Yes	☐ No
21- Have you ever been hospitalized?	☐ Yes	☐ No
22- Suicide attempt	☐ Yes	☐ No
23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)	☐ Yes	☐ No
24- Dizziness	☐ Yes	☐ No
25- Varicose veins/piles	☐ Yes	☐ No

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

26- Allergies to any medication, food, etc..?	☐ **Yes**	☐ **No**
27- Hernia	☐ **Yes**	☐ **No**
28- Amputation	☐ **Yes**	☐ **No**
29- Have you ever been signed off as sick or repatriated from a ship?	☐ **Yes**	☐ **No**
30- Have you ever been declared unfit for sea duty?	☐ **Yes**	☐ **No**
31- Do you feel healthy and fit to perform the duties of your designated position/occupation?	☐ **Yes**	☐ **No**
32- Any health problem, which requires visits to the doctor, or for which you take regular drugs? **If any of the above questions were answered "yes", please give details by referencing the item number.** **Provide information regarding diagnosis and treatment, including dates of treatment.**	☐ **Yes**	☐ **No**
Occupational history:		
33- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? **IF YES,** **Industry: ----------** **Job title: ----------** **Employer address: ----------** **Dates of employment: ----------** **Type of exposure……** **Duration of exposure…….** **Refer to Occupational Exposure questionnaire**	☐ **Yes**	☐ **No**
34- Have you ever received worker's disability benefits/ compensation?	☐ **Yes**	☐ **No**
35- Have you been absent from work for medical reasons in the past five years?	☐ **Yes**	☐ **No**
36- Have you ever required light or restricted duty? **List type and duration**	☐ **Yes**	☐ **No**
37- Have you ever had any occupational illness	☐ **Yes**	☐ **No**
If any of the above questions were answered "yes", please give details by referencing item number.		
Do you use:		
Tobacco (Cigarettes, Shisha, pipe, Vape, …….)	☐ **Yes**	☐ **No**
Alcohol	☐ **Yes**	☐ **No**
Substance	☐ **Yes**	☐ **No**
If yes, ☐ **Current use** ☐ **Previous use** **Give details:**		
Were you subjected to medical examinations (within the past 6 months)	☐ **Yes**	☐ **No**
If yes, please Specify:		
- Type of assessment: ----------		
- Purpose : ----------		
- Medical facility : ----------		
- Date of examination: ----------		
- Attach results if applicable. :----------		
:Vaccination information		
?If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA ☐ **Yes** ☐ **No**		

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

PHYSICAL EXAMINATION		
General:		
Height (cm):	**Weight (Kg):**	**BMI (consider waist- to-hip ratio as best alternative)**
Pulse rate: _____/min **Regular ☐ Irregular ☐** **Respiratory rate: _____/min**	**Blood pressure (mm Hg):** **Systolic: _____** **Diastolic: _____**	**Temperature**
Vision: Visual Acuity		
Unaided		**Aided**
Rt. Eye **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**		**Rt. Eye** **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**
(Tick the appropriate)		
Visual field		
Rt. Eye	**Normal**	**Defective**
Lt. Eye	**Normal**	**Defective**
Color vision: ☐ Normal ☐ Defective: Red-green/others		
Hearing:		
Whisper test (6 feet):		
RIGHT EAR PASS FAIL		**LEFT EAR PASS FAIL**
IF IMPAIRED, AUDIOMETRY SHOULD BE DONE		
Physical Findings: **(Circle the appropriate)**		
General Appearance		**☐ Normal ☐ Abnormal**
1- Pallor		**☐ Normal ☐ Abnormal**
2- Edema		**☐ Normal ☐ Abnormal**
3- Jaundice		**☐ Normal ☐ Abnormal**
4- Heart (Rhythm, sounds and murmurs)		**☐ Normal ☐ Abnormal**
5- Cognitive functions		**☐ Normal ☐ Abnormal**
6- Psychiatric (appearance, behavior, mood, thoughts and communication, and memory)		**☐ Normal ☐ Abnormal**
7- Mouth/teeth		**☐ Normal ☐ Abnormal**
8- Ears, nose, throat Sinuses, tympanic membrane		**☐ Normal ☐ Abnormal**
9- Eyes		**☐ Normal ☐ Abnormal**
10- Ophthalmoscopy		**☐ Normal ☐ Abnormal**
11- Pupils		**☐ Normal ☐ Abnormal**
12- Eye movement		**☐ Normal ☐ Abnormal**
13- Varicose veins		**☐ Normal ☐ Abnormal**
14- Anus (Not including digital examination)		**☐ Normal ☐ Abnormal**
15- Lung and Chest (not including breast exam)		**☐ Normal ☐ Abnormal**
16- Abdomen (including organomegaly and hernia)		**☐ Normal ☐ Abnormal**
17- Urinary and genital system (not including pelvic exam)		**☐ Normal ☐ Abnormal**
18- Upper & lower extremities (strength and range of motion)		**☐ Normal ☐ Abnormal**
19- Spine		**☐ Normal ☐ Abnormal**
20- Neurological (Equilibrium, tendon reflexes, coordination, etc.,)		**☐ Normal ☐ Abnormal**
21- Skin		**☐ Normal ☐ Abnormal**
Details of abnormality:----------		

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

Investigation

- Urine Analysis
- HIV Ab and Hepatitis screening
- HbA1C (only if known diabetic or abnormal urinalysis)
- Electrocardiogram (ECG) (above age of 40 years only)
- Chest X-ray Post-Ant view (CXR-PA), (if clinically indicated).
- Audiometry (if clinically indicated or as baseline for applicable jobs)

PROFESSIONAL LICENSE OR CERTIFICATE

If you are professionally licensed or certified to perform your current job (pilot, ship crew, respirator user, crane operator, firefighter, and others) please attach a copy of your professional license or certificate.

Note:

Copies of all investigation reports, X-ray reports, etc … should be attached to this form as part of the record.

FINAL DECISION OF PRE-PLACEMENT MEDICAL EXAMINATION REPORT

Assessment of fitness for service at sea

On the basis of the examinee's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the examinee medically:

☐ Fit for look-out duty		☐ Not fit for look-out duty		
	Deck service	Engine service	Catering service	Other services
Fit	☐	☐	☐	☐
Unfit	☐	☐	☐	☐
☐ Without restrictions	☐ With restrictions	Visual aid required	☐ Yes ☐ No	

Job title: Name of the candidate:

Job code:

ID TYPE: (NATIONAL ID) (PASSPORT)

ID NUMBER:

(Attach copy)

Medical opinion based on:

- FIT
- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:
- FIT with considerations
- FIT with restrictions.
- UNFIT

Medical certificate's date of expiration (day/month/year):

Name of Heath Professional:

Signature

Date:

المرفق ٣: نموذج

(FOOD HANDLERS MEDICAL SHEET)

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information		
Job Code:		**Job Title:** **Date of joining current job:**
Name in full (last, first, middle):	**National ID:** **Iqama No**	**Employment:** ☐ **New hire** ☐ **Rehire**
Date of birth :	**Gender :** ☐ **Male** ☐ **Female**	**Marital Status:** ☐ **Single** ☐ **Married (IF Yes)** ☐ **Pregnant (If applicable)** ☐ **YES** ☐ **NO**
Address & telephone No.	**Email address:**	
Health Questionnaire		
Do you currently have or previously had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.		☐ **Yes** ☐ **No**
2- Chest problems (asthma, Difficulty breathing, chest tightness, coughing or others)		☐ **Yes** ☐ **No**
3- Any neurological disorder e.g. (Severe/frequent headaches, Unsteadiness, Stroke, transient ischemic attacks, Tremors, sleep disorder, paralysis) or others		☐ **Yes** ☐ **No**
4- Epilepsy, Convulsions or loss of consciousness		☐ **Yes** ☐ **No**

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/ dislocations)	☐ Yes	☐ No
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)	☐ Yes	☐ No
7- Any Eye/vision problem or color blindness	☐ Yes	☐ No
8- Thyroid or other endocrine problem	☐ Yes	☐ No
9- Diabetes	☐ Yes	☐ No
10- Ear, nose, throat, Hearing difficulties, tinnitus, or Motion sickness requiring medication	☐ Yes	☐ No
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others	☐ Yes	☐ No
12- Urinary problem (Kidney, Bladder or Prostate)	☐ Yes	☐ No
13- Skin problem (e.g. allergies or dermatitis)	☐ Yes	☐ No
14- Infectious/contagious diseases	☐ Yes	☐ No
15- Tuberculosis	☐ Yes	☐ No
16- Digestive problem	☐ Yes	☐ No
17- Sleeping Disorders (OSA or Day Time Sleepiness)	☐ Yes	☐ No
18- Significant injuries	☐ Yes	☐ No
19- Cancer	☐ Yes	☐ No
20- Have you ever had any surgeries?	☐ Yes	☐ No
21- Have you ever been hospitalized?	☐ Yes	☐ No
22- Suicide attempt	☐ Yes	☐ No
23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)	☐ Yes	☐ No
24- Liver disease		
25- Deformity		
26- Jaundice		
27- Are you currently, or have you over the last seven days, suffered from diarrhea/vomiting?	☐ Yes	☐ No
28- At present, are you suffering from : i. Skin trouble affecting hands, arms or face ii. Boils, styes or sepsis on your fingers or hands iii. Discharge from eye, ear or gums/mouth	☐ Yes	☐ No
29- Do you suffer from : i. Recurring skin or ear infection ? ii. A recurring bowel disorder	☐ Yes	☐ No
30- In the last 5 days, have you been in contact with anyone who may have been suffering from cholera?	☐ Yes	☐ No
31- In the last 7 days, have you been in contact with anyone with diarrhoea or vomiting?	☐ Yes	☐ No
32- In the last 21 days have you been in contact with anyone who may have been suffering from typhoid or paratyphoid or jaundice person?	☐ Yes	☐ No
33- Have you ever had, or are you now known to be a carrier of typhoid or paratyphoid? Or do not have a certificate of antityphoid vaccine (valid for 3 years)	☐ Yes	☐ No
34- Have you ever had, or are you now known to have typhoid fever?	☐ Yes	☐ No

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

35- Any health problem, which requires visits to the doctor, or for which you take regular drugs? **If any of the above questions were answered "yes", please give details by referencing the item number.** **Provide information regarding diagnosis and treatment, including dates of treatment.**	☐ Yes	☐ No
Occupational history:		
36- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? **IF YES,** **Industry: ----------** **Job title: ----------** **Employer address: ----------** **Dates of employment: ----------** **Type of exposure……** **Duration of exposure…….** **Refer to Occupational Exposure questionnaire**	☐ Yes	☐ No
37- Have you ever received worker's disability/ compensation?	☐ Yes	☐ No
38- Have you been absent from work for medical reasons in the past five years?	☐ Yes	☐ No
39- Have you ever required light or restricted duty? **List type and duration**	☐ Yes	☐ No
40- Have you ever had any occupational illness	☐ Yes	☐ No
If any of the above questions were answered "yes", please give details by referencing item number.		
Do you use :		
Tobacco (Cigarettes, Shisha, pipe, Vape, …….)	☐ Yes	☐ No
Alcohol	☐ Yes	☐ No
Substance	☐ Yes	☐ No
If yes, ☐ **Current use** ☐ **Previous use** **Give details:**		
Were you subjected to medical examinations (within the past 6 months)	☐ Yes	☐ No
2. If yes, please Specify :		
- Type of assessment: ----------		
- Purpose: ----------		
- Medical facility: ----------		
- Date of examination: ----------		
- Attach results if applicable. :----------		
Vaccination information:		
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA? ☐ **Yes** ☐ **No**		
PHYSICAL EXAMINATION		
General:		

Height (cm):	**Weight (Kg):**	**BMI (consider waist- to-hip ratio as best alternative)**
Pulse rate: _____/min ☐ **Regular** ☐ **Irregular** **Respiratory rate: _____/min**	**Blood pressure (mm Hg):** **Systolic: _____** **Diastolic: _____**	**Temperature**
Vision: Visual Acuity		
Unaided	**Aided**	

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

Rt. Eye Distant: /20 Near: /20 Lt. Eye Distant: /20 Near: /20	Rt. Eye Distant: /20 Near: /20 Lt. Eye Distant: /20 Near: /20
(Tick the appropriate)	
Visual field	
Rt. Eye	Normal ☐ Defective ☐
Lt. Eye	Normal ☐ Defective ☐
Color vision: ☐ Normal	☐ Defective: Red-green/others
Hearing:	
Whisper test (6 feet):	
RIGHT EAR PASS FAIL	LEFT EAR PASS FAIL
IF IMPAIRED, AUDIOMETRY SHOULD BE DONE	
Physical Findings: (Circle the appropriate)	
General Appearance	☐ Normal ☐ Abnormal
1- Pallor	☐ Normal ☐ Abnormal
2- Edema	☐ Normal ☐ Abnormal
3- Jaundice	☐ Normal ☐ Abnormal
4- Eye	☐ Normal ☐ Abnormal
5- Conjunctiva	☐ Normal ☐ Abnormal
6- Clubbing	☐ Normal ☐ Abnormal
7- Cyanosis	☐ Normal ☐ Abnormal
8- Cervical lymph node enlargement	☐ Normal ☐ Abnormal
9- Nails conditions	☐ Normal ☐ Abnormal
10- Heart (Rhythm, sounds and murmurs)	☐ Normal ☐ Abnormal
11- Cognitive functions	☐ Normal ☐ Abnormal
12- Psychiatric (appearance, behavior, mood, thoughts and communication, and memory, etc)	☐ Normal ☐ Abnormal
13- Mouth/teeth	☐ Normal ☐ Abnormal
14- Ears, nose, throat	☐ Normal ☐ Abnormal
15- Lung and Chest (not including breast exam)	☐ Normal ☐ Abnormal
16- Abdomen (including organomegaly and hernia)	☐ Normal ☐ Abnormal
17- Urinary and genital system (not including pelvic exam)	☐ Normal ☐ Abnormal
18- Upper & lower extremities (strength and range of motion)	☐ Normal ☐ Abnormal
19- Spine	☐ Normal ☐ Abnormal
20- Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Normal ☐ Abnormal
21- Skin	☐ Normal ☐ Abnormal
Details of abnormality:----------	

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

Investigation

- **Complete Urine Analysis**
- HbA1C (only if known diabetic or abnormal urinalysis)
- Electrocardiogram (ECG) (above the age of 40 years only)
- Chest X-ray Post-Ant view (CXR-PA) (if clinically indicated).
- Audiometry (if clinically indicated or as baseline for applicable jobs)
- QuantiFERON test
- Widal test
- Stool examination for ova & parasite
- Stool culture and sensitivity for S. typhi to R/O Typhoid carrier (if clinically indicated- History of typhoid fever)
- Stool or Rectal swab culture and Sensitivity for Typhidot, Viral study to R/O Cholera, Typhoid, Shigellosis or EHEC infection (if clinically indicated - active diarrhoea with or without fever or dysentery)
- Anti- Hepatitis A Virus IgM (if clinically indicated - Jaundice and fever)

Note:

Copies of all investigation reports, X-ray reports , etc … should be attached to this form as part of the record.

FINAL DECISION OF PRE-PLACEMENT MEDICAL EXAMINATION REPORT

Job title:
Job code:

Name of the candidate:

ID TYPE: NATIONAL PASSPORT ID NUMBER:

(Attach copy)

Fitness determination:

- FIT
- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:
- FIT with considerations
- FIT with restrictions.
- UNFIT

Name of health professional:
Signature:
Date:

المرفق ٤: نموذج
(DIVING MEDICAL SHEET)

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information		
Job Code:	**Job Title:** **Date of joining current job:**	
Name in full (last, first, middle):	**National ID:** **Iqama No**	**Employment:** ☐ **New hire** ☐ **Rehire**
Date of birth:	**Gender:** ☐ **Male** ☐ **Female**	**Marital Status:** ☐ **Single** ☐ **Married (IF Yes)** ☐ **Pregnant (If applicable)** ☐ **Yes** ☐ **No**
Address & telephone No.	**Email address:**	
Health Questionnaire		
Do you currently have or previously had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.		☐ **Yes** ☐ **No**
2- Chest problems (asthma, Difficulty breathing, chest tightness, coughing or others)		☐ **Yes** ☐ **No**
3- Any neurological disorder e.g. (Severe/frequent headaches, Unsteadiness, Stroke, transient ischemic attacks, Tremors, sleep disorder, paralysis) or others		☐ **Yes** ☐ **No**
4- Epilepsy, Convulsions or loss of consciousness		☐ **Yes** ☐ **No**
5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/dislocations)		☐ **Yes** ☐ **No**
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)		☐ **Yes** ☐ **No**

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

7- Any Eye/vision problem or color blindness	☐ Yes	☐ No
8- Thyroid or other endocrine problem	☐ Yes	☐ No
9- Diabetes	☐ Yes	☐ No
10- Ear, nose, throat, sinuses, Hearing difficulties, tinnitus, or Motion sickness requiring medication	☐ Yes	☐ No
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others	☐ Yes	☐ No
12- Urinary problem (Kidney, Bladder or Prostate)	☐ Yes	☐ No
13- Skin problem (e.g. allergies or dermatitis)	☐ Yes	☐ No
14- Infectious/contagious diseases	☐ Yes	☐ No
15- Tuberculosis	☐ Yes	☐ No
16- Digestive problem	☐ Yes	☐ No
17- Sleeping Disorders (OSA or Day Time Sleepiness)	☐ Yes	☐ No
18- Significant injuries	☐ Yes	☐ No
19- Cancer	☐ Yes	☐ No
20- Have you ever had any surgeries?	☐ Yes	☐ No
21- Have you ever been hospitalized?	☐ Yes	☐ No
22- Suicide attempt	☐ Yes	☐ No
23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)	☐ Yes	☐ No
24- Have you ever had any diving related condition, eg barotrauma, decompression illness, immersion pulmonary oedema?	☐ Yes	☐ No
25- Do you have any allergies?	☐ Yes	☐ No
26- Do you have a family history of sudden cardiac death and/or abnormalities of heart rhythm?	☐ Yes	☐ No
27- COVID-19	☐ Yes	☐ No
28- Collapsed lung (pneumothorax)	☐ Yes	☐ No
29- Dizziness	☐ Yes	☐ No
30- Migraine	☐ Yes	☐ No
31- Head injury with loss of consciousness, or surgery to the skull or brain	☐ Yes	☐ No
32- Mental health problems (including panic attacks and claustrophobia)	☐ Yes	☐ No
33- Stomach or intestinal problems or surgery (including stomas)	☐ Yes	☐ No

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

1- Any health problem, which requires visits to the doctor, or for which you take regular drugs? If any of the above questions were answered "yes", please give details by referencing the item number. Provide information regarding diagnosis and treatment, including dates of treatment.	☐ Yes	☐ No
Occupational history:		
2- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? IF YES, Industry: ---------- Job title: ---------- Employer address: ---------- Dates of employment: ---------- Type of exposure…… Duration of exposure…… 3- Refer to Occupational Exposure questionnaire	☐ Yes	☐ No
4- Have you ever received worker's disability/ compensation?	☐ Yes	☐ No
5- Have you been absent from work for medical reasons in the past five years?	☐ Yes	☐ No
6- Have you ever required light or restricted duty? 7- List type and duration	☐ Yes	☐ No
8- Have you ever had any occupational illness	☐ Yes	☐ No
If any of the above questions were answered "yes", please give details by referencing item number.		
Do you use :		
Tobacco (Cigarettes, Shisha, pipe, Vape, …….)	☐ Yes	☐ No
Alcohol	☐ Yes	☐ No
Substance	☐ Yes	☐ No
If yes, ☐ Current use ☐ Previous use Give details:		
Were you subjected to medical examinations (within the past 6 months)	☐ Yes	☐ No
2- If yes, please Specify :		
Type of assessment: ----------		
Purpose : ----------		
Medical facility : ----------		
Date of examination : ----------		
Attach results if applicable. :----------		
Vaccination information :		
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA?	☐ Yes	☐ No
PHYSICAL EXAMINATION		

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

General:		
Height (cm):	**Weight (Kg):**	**BMI (consider hip: waist- to-hip ratio as best alternative)**
Pulse rate: _____/min ☐ **Regular** ☐ **Irregular** **Respiratory rate: _____/min**	**Blood pressure (mm Hg):** **Systolic: _____ Diastolic: _____**	**Temperature**
Vision : Visual Acuity		
Unaided	**Aided**	
Rt. Eye **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**	**Rt. Eye** **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**	
(Tick the appropriate)		
Visual field		
Rt. Eye	**Normal**	**Defective**
Lt. Eye	**Normal**	**Defective**
Color vision: ☐ **Normal**	☐ **Defective: Red-green/others**	
Hearing:		
Whisper test (6 feet):		
RIGHT EAR PASS FAIL	**LEFT EAR PASS FAIL**	
IF IMPAIRED, AUDIOMETRY SHOULD BE DONE		
Physical Findings: **(Circle the appropriate)**		
General Appearance	☐ **Yes**	☐ **No**
1- Pallor	☐ **Yes**	☐ **No**
2- Edema	☐ **Yes**	☐ **No**
3- Jaundice	☐ **Yes**	☐ **No**
4- Heart (Rhythm, sounds and murmurs)	☐ **Yes**	☐ **No**
5- Cognitive functions	☐ **Yes**	☐ **No**
6- Psychiatric (appearance, behavior, mood, thoughts and communication, and memory)	☐ **Yes**	☐ **No**
7- Mouth/teeth	☐ **Yes**	☐ **No**
8- Ears, nose, throat	☐ **Yes**	☐ **No**

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9- Lung and Chest (not including breast exam)	☐ Yes	☐ No
10- Abdomen (including organomegaly and hernia)	☐ Yes	☐ No
11- Urinary and genital system (not including pelvic exam)	☐ Yes	☐ No
12- Upper & lower extremities (strength and range of motion)	☐ Yes	☐ No
13- Spine	☐ Yes	☐ No
14- Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Yes	☐ No
15- Skin	☐ Yes	☐ No
16- Posture	☐ Yes	☐ No
17- Gait	☐ Yes	☐ No
18- Balance	☐ Yes	☐ No
19- Involuntary movements	☐ Yes	☐ No
20- Speech	☐ Yes	☐ No
21- Varicose vein	☐ Yes	☐ No
22- Cranial nerve II-XII	☐ Yes	☐ No
Details of abnormality:----------		

Investigation

- Complete Urine Analysis
- HbA1C (only if known diabetic or abnormal urinalysis)
- Electrocardiogram (ECG) (above the age of 40 years only)
- Chest X-ray Post-Ant view (CXR-PA), (if clinically indicated).
- Audiometry (if clinically indicated or as baseline for applicable jobs)
- Spirometry
- Complete blood count

- BIOLOGICAL markers (for candidate with previous exposure to establish basle line/select applicable only)
  - Lead, Pb (µg/L)
  - Manganese, Mn (µg/L)

Cadmium, Cd (µg/L)

Note:

Copies of all investigation reports, X-ray reports, etc. … should be attached to this form as part of the record.

FINAL DECISION OF PRE-PLACEMENT MEDICAL EXAMINATION REPORT

Job title: Name of the candidate:

Job code:

ID TYPE: NATIONAL PASSPORT ID NUMBER:

(Attach copy)

Fitness determination:

- FIT
- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:
- FIT with considerations
- FIT with restrictions.
- UNFIT

Name of health professional:

Signature:

Date:

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

المرفق ٥:

نموذج (WELDER MEDICAL SHEET)

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information		
Job Code:		Job Title: Date of joining current job:
Name in full (last, first, middle):	National ID: Iqama No	Employment: ☐ New hire ☐ Rehire
Date of birth:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married (IF Yes) ☐ Pregnant (If applicable) ☐ Yes ☐ No
Address & telephone No.	Email address:	
Health Questionnaire		
Do you currently have or previously had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.		☐ Yes ☐ No
2- Chest problems (asthma, Difficulty breathing, chest tightness, coughing or others)		☐ Yes ☐ No
3- Any neurological disorder e.g. (Severe/frequent headaches, Unsteadiness, Stroke, transient ischemic attacks, Tremors, sleep disorder, paralysis) or others		☐ Yes ☐ No
4- Epilepsy, Convulsions or loss of consciousness		☐ Yes ☐ No
5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/dislocations)		☐ Yes ☐ No
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)		☐ Yes ☐ No
7- Any Eye/vision problem or color blindness		☐ Yes ☐ No
8- Thyroid or other endocrine problem		☐ Yes ☐ No
9- Diabetes		☐ Yes ☐ No
10- Ear, nose, throat, Hearing difficulties, tinnitus, or Motion sickness requiring medication		☐ Yes ☐ No
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others		☐ Yes ☐ No
12- Urinary problem (Kidney, Bladder or Prostate)		☐ Yes ☐ No
13- Skin problem (e.g. allergies or dermatitis)		☐ Yes ☐ No
14- Infectious/contagious diseases		☐ Yes ☐ No
15- Tuberculosis		☐ Yes ☐ No
16- Digestive problem		☐ Yes ☐ No
17- Sleeping Disorders (OSA or Day Time Sleepiness)		☐ Yes ☐ No
18- Significant injuries		☐ Yes ☐ No
19- Cancer		☐ Yes ☐ No
20- Have you ever had any surgeries?		☐ Yes ☐ No
21- Have you ever been hospitalized?		
22- Suicide attempt		☐ Yes ☐ No

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23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)	☐ Yes	☐ No
24- Allergic reactions that interfere with your breathing	☐ Yes	☐ No
25- Claustrophobia	☐ Yes	☐ No
26- Smelling	☐ Yes	☐ No
27- Pulmonary symptoms (cough, wheezing, etc)	☐ Yes	☐ No
28- Eye irritation	☐ Yes	☐ No
29- Any health problem, which requires visits to the doctor, or for which you take regular drugs? If any of the above questions were answered "yes", please give details by referencing the item number. Provide information regarding diagnosis and treatment, including dates of treatment.	☐ Yes	☐ No
Occupational history:		
30- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? IF YES, Industry: ---------- Job title: ---------- Employer address: ---------- Dates of employment: ---------- Type of exposure…… Duration of exposure……. Refer to Occupational Exposure questionnaire	☐ Yes	☐ No
31- Have you ever received worker's disability/ compensation?	☐ Yes	☐ No
Have you ever worked with any of the materials, or under any of the conditions listed below?		
32- Asbestos?	☐ Yes	☐ No
33- Silica (e.g., in sandblasting)?	☐ Yes	☐ No
34- Tungsten/cobalt (e.g., grinding or welding this material)?	☐ Yes	☐ No
35- Beryllium?	☐ Yes	☐ No
36- Aluminum?	☐ Yes	☐ No
37- Coal (for example, mining)?	☐ Yes	☐ No
38- Iron?	☐ Yes	☐ No
39- Tin?	☐ Yes	☐ No
40- Dusty environments?	☐ Yes	☐ No
41- Any other hazardous exposures?	☐ Yes	☐ No
42- Have you been absent from work for medical reasons in the past five years?	☐ Yes	☐ No
43- Have you ever required light or restricted duty? List type and duration	☐ Yes	☐ No
44- Have you ever had any occupational illness	☐ Yes	☐ No
If any of the above questions were answered "yes", please give details by referencing item number.		

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Do you use:		
Tobacco (Cigarettes, Shisha, pipe, Vape, ……)	☐ **Yes**	☐ **No**
Alcohol	☐ **Yes**	☐ **No**
Substance	☐ **Yes**	☐ **No**
If yes, ☐ **Current use** ☐ **Previous use** **Give details:**		
Were you subjected to medical examinations (within the past 6 months)	☐ **Yes**	☐ **No**
2- If yes, please Specify:		
- Type of assessment: ----------		
- Purpose: ----------		
- Medical facility: ----------		
- Date of examination: ----------		
- Attach results if applicable. :----------		
Vaccination information:		
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA? ☐ **Yes** ☐ **No**		
PHYSICAL EXAMINATION		
General:		

Height (cm):	**Weight (Kg):**	**BMI (consider hip: waist- to-hip ratio as best alternative)**
Pulse rate: _____/min ☐ **Regular** ☐ **Irregular** **Respiratory rate: _____/min**	**Blood pressure (mm Hg):** **Systolic: _____ Diastolic: _____**	**Temperature**

Vision: Visual Acuity	
Unaided	**Aided**
Rt. Eye **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**	**Rt. Eye** **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**
(Tick the appropriate)	
Visual field	

Rt. Eye	**Normal**	**Defective**
Lt. Eye	**Normal**	**Defective**

Color vision:	☐ **Normal**	☐ **Defective: Red-green/others**
Hearing:		
Whisper test (6 feet):		

RIGHT EAR	**PASS**	**FAIL**	**LEFT EAR**	**PASS**	**FAIL**

IF IMPAIRED, AUDIOMETRY SHOULD BE DONE
Physical Findings: **(Circle the appropriate)**

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General Appearance	☐ Normal ☐ Abnormal
1- Pallor	☐ Normal ☐ Abnormal
2- Edema	☐ Normal ☐ Abnormal
3- Jaundice	☐ Normal ☐ Abnormal
4- Heart (Rhythm, sounds and murmurs)	☐ Normal ☐ Abnormal
5- Cognitive functions	☐ Normal ☐ Abnormal
6- Psychiatric (appearance, behavior, mood, thoughts and communication, and memory)	☐ Normal ☐ Abnormal
7- Mouth (Tongue and tonsils), teeth and gums	☐ Normal ☐ Abnormal
8- Ears, nose, throat	☐ Normal ☐ Abnormal
9- Thyroid exam	☐ Normal ☐ Abnormal
10- Lymph node	☐ Normal ☐ Abnormal
11- Eye exam	☐ Normal ☐ Abnormal
12- Lung and Chest (not including breast exam)	☐ Normal ☐ Abnormal
13- Abdomen (including organomegaly and hernia)	☐ Normal ☐ Abnormal
14- Urinary and genital system (not including pelvic exam)	☐ Normal ☐ Abnormal
15- Upper & lower extremities (strength and range of motion)	☐ Normal ☐ Abnormal
16- Spine	☐ Normal ☐ Abnormal
17- Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Normal ☐ Abnormal
18- Skin	☐ Normal ☐ Abnormal
Details of abnormality:----------	

Investigation

- Complete Urine Analysis
- HbA1C (only if known diabetic or abnormal urinalysis)
- Electrocardiogram (ECG) (above the age of 40 years only)
- Chest X-ray Post-Ant view (CXR-PA), (if clinically indicated).
- Audiometry (if clinically indicated or as baseline for applicable jobs)
- Spirometry
- Complete blood count
- BIOLOGICAL markers (for candidate with previous exposure to establish basle line/select applicable only)
- Lead, Pb (µg/L)
- Manganese, Mn (µg/L)
- Cadmium, Cd (µg/L)

Note:
Copies of all investigation reports, X-ray reports, etc. … should be attached to this form as part of the record.

FINAL DECISION OF PRE-PLACEMENT MEDICAL EXAMINATION REPORT

Job title: Name of the candidate:
Job code:

ID TYPE: NATIONAL PASSPORT ID NUMBER:

(Attach copy)
Fitness determination:
- FIT
- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:
- FIT with considerations
- FIT with restrictions.
- UNFIT

Name of health professional:
Signature:
Date:

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

المرفق ٦:

نموذج (PERIODIC MEDICAL ASSESSMENTS)

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information		
Job Code:		**Job Title:** **Date of joining current job :**
Name in full (last, first, middle):	**National ID:** **Iqama No**	**Employment:** ☐ **New hire** ☐ **Rehire**
Date of birth:	**Gender:** ☐ **Male** ☐ **Female**	**Marital Status:** ☐ **Single** ☐ **Married** **(IF Yes)** ☐ **Pregnant (If applicable)** ☐ **Yes** ☐ **No**
Address & telephone No.	**Email address:**	

Health Questionnaire		
Do you currently have or previously had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.	☐ **Yes**	☐ **No**
2- Chest problems (asthma, Difficulty breathing, chest tightness, coughing or others)	☐ **Yes**	☐ **No**
3- Any neurological disorder e.g. (Severe/frequent headaches, Unsteadiness, Stroke, transient ischemic attacks, Tremors, sleep disorder, paralysis) or others	☐ **Yes**	☐ **No**
4- Epilepsy, Convulsions or loss of consciousness	☐ **Yes**	☐ **No**
5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/dislocations)	☐ **Yes**	☐ **No**
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)	☐ **Yes**	☐ **No**
7- Any Eye/vision problem or color blindness	☐ **Yes**	☐ **No**
8- Thyroid or other endocrine problem	☐ **Yes**	☐ **No**
9- Diabetes	☐ **Yes**	☐ **No**
10- Ear, nose, throat, Hearing difficulties, tinnitus, or Motion sickness requiring medication	☐ **Yes**	☐ **No**
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others	☐ **Yes**	☐ **No**
12- Urinary problem (Kidney, Bladder or Prostate)	☐ **Yes**	☐ **No**
13- Skin problem (e.g. allergies or dermatitis)	☐ **Yes**	☐ **No**
14- Infectious/contagious diseases	☐ **Yes**	☐ **No**
15- Tuberculosis	☐ **Yes**	☐ **No**
16- Digestive problem	☐ **Yes**	☐ **No**
17- Sleeping Disorders (OSA or Day Time Sleepiness)	☐ **Yes**	☐ **No**
18- Significant injuries	☐ **Yes**	☐ **No**
19- Cancer	☐ **Yes**	☐ **No**
20- Have you ever had any surgeries?	☐ **Yes**	☐ **No**
21- Have you ever been hospitalized?	☐ **Yes**	☐ **No**
22- Suicide attempt	☐ **Yes**	☐ **No**

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23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)	☐ Yes ☐ No
24- Any health problem, which requires visits to the doctor, or for which you take regular drugs? **If any of the above questions were answered "yes", please give details by referencing the item number.** **Provide information regarding diagnosis and treatment, including dates of treatment.**	☐ Yes ☐ No
Occupational history:	
25- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? **IF YES,** **Industry: ----------** **Job title: ----------** **Employer address: ----------** **Dates of employment: ----------** **Type of exposure……** **Duration of exposure…….** **Refer to Occupational Exposure questionnaire**	☐ Yes ☐ No
26- Have you ever received worker's disability/ compensation?	☐ Yes ☐ No
27- Have you been absent from work for medical reasons in the past five years?	☐ Yes ☐ No
28- Have you ever required light or restricted duty? **List type and duration**	☐ Yes ☐ No
29- Have you ever had any occupational illness	☐ Yes ☐ No
If any of the above questions were answered "yes", please give details by referencing item number.	
Do you use:	
Tobacco (Cigarettes, Shisha, pipe, Vape, …….)	☐ Yes ☐ No
Alcohol	☐ Yes ☐ No
Substance	☐ Yes ☐ No
,If yes **Current use ☐ Previous use ☐** **:Give details**	
Were you subjected to medical examinations (within the past 6 months)	☐ Yes ☐ No
2- If yes, please Specify:	
- Type of assessment: ----------	
- Purpose : ----------	
- Medical facility : ----------	
- Date of examination : ----------	
- Attach results if applicable. :----------	
Vaccination information:	
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA? **☐ Yes ☐ No**	
PHYSICAL EXAMINATION	

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General:		
Height (cm):	**Weight (Kg):**	**BMI (consider hip: waist- to-hip ratio as best alternative)**
Pulse rate: _____/min ☐ **Regular** ☐ **Irregular** **Respiratory rate: _____/min**	**Blood pressure (mm Hg):** **Systolic: _____ Dia-stolic: _____**	**Temperature**
Vision: Visual Acuity		
Unaided		**Aided**
Rt. Eye **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**		**Rt. Eye** **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**
(Tick the appropriate)		
Visual field		
Rt. Eye	**Normal**	**Defective**
Lt. Eye	**Normal**	**Defective**
Hearing:		
Whisper test (6 feet):		
RIGHT EAR PASS FAIL		**LEFT EAR PASS FAIL**
IF IMPAIRED, AUDIOMETRY SHOULD BE DONE		
Physical Findings: **(Circle the appropriate)**		
General Appearance		☐ **Normal** ☐ **Abnormal**
1- Pallor		☐ **Normal** ☐ **Abnormal**
2- Edema		☐ **Normal** ☐ **Abnormal**
3- Jaundice		☐ **Normal** ☐ **Abnormal**
4- Heart (Rhythm, sounds and murmurs)		☐ **Normal** ☐ **Abnormal**
5- Cognitive functions		☐ **Normal** ☐ **Abnormal**
6- Psychiatric (appearance, behavior, mood, thoughts and communication, and memory)		☐ **Normal** ☐ **Abnormal**
7- Mouth/teeth		☐ **Normal** ☐ **Abnormal**
8- Ears, nose, throat		☐ **Normal** ☐ **Abnormal**
9- Lung and Chest (not including breast exam)		☐ **Normal** ☐ **Abnormal**
10- Abdomen (including hernia)		☐ **Normal** ☐ **Abnormal**
11- Urinary and genital system (not including pelvic exam)		☐ **Normal** ☐ **Abnormal**
12- Upper & lower extremities (strength and range of motion)		☐ **Normal** ☐ **Abnormal**

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Physical Findings: (Circle the appropriate)	
13- Spine	☐ Normal ☐ Abnormal
14- Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Normal ☐ Abnormal
15- Skin	☐ Normal ☐ Abnormal

Details of abnormality:----------

Investigation

- Urine Analysis
- Chest X-ray Post-Ant view (CXR-PA) (if clinically indicated)
- Electrocardiogram (ECG) (above 40 years)
- Audiometry (if whisper test is positive)

HEAVY EQUIPMENT OPERATOR (every 3 years)

- Urine Drug Screening (Random)

HEALTHCARE (every two years for high risk jobs):

- HBV, HCV, and HIV screening (If vaccinated against HBV, a HBsAb titer should be performed).
- Interferon-gamma release assay (IGRA) (annual testing with baseline negative test).
- Respiratory FIT testing (if not already done).
- Urine Drug Screening (Random).

Occupationally Exposed Radiation Workers (every three (3) years)

- Complete Blood Count (CBC) with differential.

For over exposures, accidental exposure, pregnant or breast feeding radiation workers (follow Exposure Guidelines).

MINING UNDERGROUND (every three years):

- Chest X-ray Post-Ant view (CXR-PA), (baseline and every 3 years and annually after 10 years of exposure).
- Spirometry and respiratory fit testing (baseline).
- Audiometry (baseline).
- Urine Drug Screening (Random).
- Respiratory FIT testing (if needed).

COMMERCIAL DRIVER (every two years):

- Audiometry (periodic) average hearing loss of 0.5,1.0&2.0 kHz in better ear < 40dBA
- Visual field assessment if clinically indicated

AIRCRAFT (annual):

- Follow GACA roles for periodic physical

FIRE FIGHTER (every two years) :

- Aerobic capacity (minimum MET level of 12)

-Harvard Step Test or Chester treadmill walk test or Bruce protocol or equivalent

- CBC with differential, RBC indices and morphology, and platelet count
- Renal function test
- Fasting blood glucose
- Liver function test
- Lipid profile
- HIV Ab
- Hepatitis C screening + confirmation only if positive baseline and following occupational exposure
- Hepatitis B base line (HBsAg) and vaccination with titers 1-2 months after completion of 3 dose series.
- Tetanus/diphtheria /pertussis (Tdap) vaccine once then Td booster every 10 years
- Document (MMR) or provide two doses according to immunization guidelines.
- Spirometry: annually to measure (FVC), (FEV1), and the absolute FEV1/FVC ratio
- Urine Drug Screening

PROFESSIONAL LICENSE OR CERTIFICATE

If you are professionally licensed or certified to perform your current job (pilot, ship crew, respirator user, crane operator, firefighter and others) please attach a copy of your professional license or certificate.

Note:

Copies of all investigation reports, X-ray reports , etc … should be attached to this form as part of the record.

FINAL DECISION OF PRE-PLACEMENT MEDICAL EXAMINATION REPORT

Job title: Name of the candidate:

Job code:

ID TYPE: NATIONAL PASSPORT ID NUMBER:

(Attach copy)

Fitness determination:

- FIT
- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:
- FIT with considerations
- FIT with restrictions.
- UNFIT

Name of health professional:

Signature:

Date:

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

المرفق ٧:

نموذج (DIVING MEDICAL SHEET-)

ANNUAL

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information		
Job Code:		Job Title:
Name in full (last, first, middle):	National ID: Iqama No	Employment: ☐ New hire ☐ Rehire
Date of birth:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married (IF Yes) ☐ Pregnant (If applicable) ☐ Yes ☐ No
Address & telephone No.	Email address:	

Health Questionnaire		
Do you currently have or previously had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.	☐ Yes	☐ No
2- Chest problems (asthma, Difficulty breathing, chest tightness, coughing or others)	☐ Yes	☐ No
3- Any neurological disorder e.g. (Severe/frequent headaches, Unsteadiness, Stroke, transient ischemic attacks, Tremors, sleep disorder, paralysis) or others	☐ Yes	☐ No
4- Epilepsy, Convulsions or loss of consciousness	☐ Yes	☐ No
5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/dislocations)	☐ Yes	☐ No
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)	☐ Yes	☐ No
7- Any Eye/vision problem or color blindness	☐ Yes	☐ No
8- Thyroid or other endocrine problem	☐ Yes	☐ No
9- Diabetes	☐ Yes	☐ No
10- Ear, nose, throat, sinuses, Hearing difficulties, tinnitus, or Motion sickness requiring medication	☐ Yes	☐ No
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others	☐ Yes	☐ No
12- Urinary problem (Kidney, Bladder or Prostate)	☐ Yes	☐ No
13- Skin problem (e.g. allergies or dermatitis)	☐ Yes	☐ No
14- Infectious/contagious diseases	☐ Yes	☐ No
15- Tuberculosis	☐ Yes	☐ No
16- Digestive problem	☐ Yes	☐ No
17- Sleeping Disorders (OSA or Day Time Sleepiness)	☐ Yes	☐ No
18- Significant injuries	☐ Yes	☐ No
19- Cancer	☐ Yes	☐ No
20- Have you ever had any surgeries?	☐ Yes	☐ No
21- Have you ever been hospitalized?	☐ Yes	☐ No

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22- Suicide attempt	☐ Yes	☐ No
23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)	☐ Yes	☐ No
24- Have you ever had any diving related condition, eg barotrauma, decompression illness, immersion pulmonary oedema?	☐ Yes	☐ No
25- Do you have any allergies?	☐ Yes	☐ No
26- Do you have a family history of sudden cardiac death and/or abnormalities of heart rhythm?	☐ Yes	☐ No
27- COVID-19	☐ Yes	☐ No
28- Collapsed lung (pneumothorax)	☐ Yes	☐ No
29- Dizziness	☐ Yes	☐ No
30- Migraine	☐ Yes	☐ No
31- Head injury with loss of consciousness, or surgery to the skull or brain	☐ Yes	☐ No
32- Mental health problems (including panic attacks and claustrophobia)	☐ Yes	☐ No
33- Stomach or intestinal problems or surgery (including stomas)	☐ Yes	☐ No
34- Any health problem, which requires visits to the doctor, or for which you take regular drugs? If any of the above questions were answered "yes", please give details by referencing the item number. Provide information regarding diagnosis and treatment, including dates of treatment.	☐ Yes	☐ No
:Occupational history		
35- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? IF YES, Industry: ---------- Job title: ---------- Employer address: ---------- Dates of employment: ---------- Type of exposure…… Duration of exposure……. Refer to Occupational Exposure questionnaire	☐ Yes	☐ No
36- Have you ever received worker's disability/ compensation?	☐ Yes	☐ No
37- Have you been absent from work for medical reasons in the past five years?	☐ Yes	☐ No
38- Have you ever required light or restricted duty? List type and duration	☐ Yes	☐ No
39- Have you ever had any occupational illness	☐ Yes	☐ No
If any of the above questions were answered "yes", please give details by referencing item number.		
Do you use :		
Tobacco (Cigarettes, Shisha, pipe, Vape, …….)	☐ Yes	☐ No
Alcohol	☐ Yes	☐ No
Substance	☐ Yes	☐ No
If yes, ☐ Current use ☐ Previous use Give details:		
Were you subjected to medical examinations (within the past 6 months)	☐ Yes	☐ No

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

2- If yes, please Specify:		
- Type of assessment: ----------		
- Purpose: ----------		
- Medical facility: ----------		
- Date of examination: ----------		
- Attach results if applicable:----------		
Vaccination information :		
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA? ☐ **Yes** ☐ **No**		
PHYSICAL EXAMINATION		
General:		
Height (cm):	**Weight (Kg):**	**BMI(consider waist- to-hip ratio as best alternative)**
Pulse rate: _____/min ☐ **Regular** ☐ **Irregular** **Respiratory rate: _____/min**	**Blood pressure (mm Hg):** **Systolic: _____ Diastolic: _____**	**Temperature**
Vision : Visual Acuity		
Unaided		**Aided**
Rt. Eye **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**		**Rt. Eye** **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**
(Tick the appropriate)		
Visual field		
Rt. Eye	**Normal**	**Defective**
Lt. Eye	**Normal**	**Defective**
Color vision: ☐ **Normal**	☐ **Defective: Red-green/others**	
Hearing:		
Whisper test (6 feet):		
RIGHT EAR PASS FAIL		**LEFT EAR PASS FAIL**
IF IMPAIRED, AUDIOMETRY SHOULD BE DONE		
Physical Findings: **(Circle the appropriate)**		
General Appearance		☐ **Normal** ☐ **Abnormal**
1- Pallor		☐ **Normal** ☐ **Abnormal**
2- Edema		☐ **Normal** ☐ **Abnormal**
3- Jaundice		☐ **Normal** ☐ **Abnormal**
4- Heart (Rhythm, sounds and murmurs)		☐ **Normal** ☐ **Abnormal**
5- Cognitive functions		☐ **Normal** ☐ **Abnormal**

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6- Psychiatric (appearance, behavior, mood, thoughts and communication, and memory)	☐ Normal ☐ Abnormal
7- Mouth/teeth	☐ Normal ☐ Abnormal
8- Ears, nose, throat	☐ Normal ☐ Abnormal
9- Lung and Chest (not including breast exam)	☐ Normal ☐ Abnormal
10- Abdomen (including organomegaly and hernia)	☐ Normal ☐ Abnormal
11- Urinary and genital system (not including pelvic exam)	☐ Normal ☐ Abnormal
12- Upper & lower extremities (strength and range of motion)	☐ Normal ☐ Abnormal
13- Spine	☐ Normal ☐ Abnormal
14- Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Normal ☐ Abnormal
15- Skin	☐ Normal ☐ Abnormal
16- Posture	☐ Normal ☐ Abnormal
17- Gait	☐ Normal ☐ Abnormal
18- Balance	☐ Normal ☐ Abnormal
19- Involuntary movements	☐ Normal ☐ Abnormal
20- Speech	☐ Normal ☐ Abnormal
21- Varicose vein	☐ Normal ☐ Abnormal
22- Cranial nerve II-XII	☐ Normal ☐ Abnormal
Details of abnormality:----------	

Investigation

- Complete Urine Analysis
- HbA1C (only if known diabetic or abnormal urinalysis)
- Electrocardiogram (ECG) (above the age of 40 years only)
- Chest X-ray Post-Ant view (CXR-PA), (if clinically indicated).
- Audiometry (if clinically indicated)
- Aerobic capacity (minimum MET level of 12)

Harvard Step Test or Chester treadmill walk test or Bruce protocol or equivalent

- Exercise test
- Spirometry
- Post-exercise PEF or FEV1
- Audiometry
- Complete blood count (if clinically indicated)

PROFESSIONAL LICENSE OR CERTIFICATE

If you are professionally licensed or certified to perform your current job (pilot, ship crew, respirator user, crane operator, firefighter and others) please attach a copy of your professional license or certificate.

Note:

Copies of all investigation reports, X-ray reports , etc … should be attached to this form as part of the record.

FINAL DECISION OF PRE-PLACEMENT MEDICAL EXAMINATION REPORT

Job title: Name of the candidate:

Job code:

ID TYPE: NATIONAL PASSPORT ID NUMBER:

(Attach copy)

Fitness determination:

- FIT
- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:
- FIT with considerations
- FIT with restrictions.
- UNFIT

Name of health professional:

Signature:

Date:

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

المرفق ٨:
نموذج (MINING MEDICAL SHEET)
EVERY 3 YEARS UNTIL AGE OF 50, THEN EVERY ONE YEAR.

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information		
Job Code:		Job Title:
Name in full (last, first, middle):	National ID: Iqama No	Employment: ☐ New hire ☐ Rehire
Date of birth:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married (IF Yes) ☐ Pregnant (If applicable) ☐ Yes ☐ No
Address & telephone No.	Email address:	
Health Questionnaire		
Do you currently have or previously had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.		☐ Yes ☐ No
2- Chest problems (asthma, Difficulty breathing, chest tightness, coughing or others)		☐ Yes ☐ No
3- Any neurological disorder e.g. (Severe/frequent headaches, Unsteadiness, Stroke, transient ischemic attacks, Tremors, sleep disorder, paralysis) or others		☐ Yes ☐ No
4- Epilepsy, Convulsions or loss of consciousness		☐ Yes ☐ No
5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/dislocations)		☐ Yes ☐ No
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)		☐ Yes ☐ No
7- Any Eye/vision problem or color blindness		☐ Yes ☐ No
8- Thyroid or other endocrine problem		☐ Yes ☐ No
9- Diabetes		☐ Yes ☐ No
10- Ear, nose, throat, Hearing difficulties, tinnitus, or Motion sickness requiring medication		☐ Yes ☐ No
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others		☐ Yes ☐ No
12- Urinary problem (Kidney, Bladder or Prostate)		☐ Yes ☐ No
13- Skin problem (e.g. allergies or dermatitis)		☐ Yes ☐ No
14- Infectious/contagious diseases		☐ Yes ☐ No
15- Tuberculosis		☐ Yes ☐ No
16- Digestive problem		☐ Yes ☐ No
17- Sleeping Disorders (OSA or Day Time Sleepiness)		☐ Yes ☐ No
18- Significant injuries		☐ Yes ☐ No
19- Cancer		☐ Yes ☐ No
20- Have you ever had any surgeries?		☐ Yes ☐ No
21- Have you ever been hospitalized?		
22- Suicide attempt		☐ Yes ☐ No
23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)		☐ Yes ☐ No

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24- Allergic reactions that interfere with your breathing	☐ **Yes**	☐ **No**
25- Claustrophobia	☐ **Yes**	☐ **No**
26- Smelling	☐ **Yes**	☐ **No**
27- Pulmonary symptoms (cough, wheezing, etc)	☐ **Yes**	☐ **No**
28- Eye irritation	☐ **Yes**	☐ **No**
29- Any health problem, which requires visits to the doctor, or for which you take regular drugs? **If any of the above questions were answered "yes", please give details by referencing the item number.** **Provide information regarding diagnosis and treatment, including dates of treatment.**	☐ **Yes**	☐ **No**
Occupational history:		
30- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? **IF YES,** **Industry: ----------** **Job title: ----------** **Employer address: ----------** **Dates of employment: ----------** **Type of exposure……** **Duration of exposure…….** **Refer to Occupational Exposure questionnaire**	☐ **Yes**	☐ **No**
31- Have you ever received worker's disability/ compensation?	☐ **Yes**	☐ **No**
Have you ever worked with any of the materials, or under any of the conditions listed below?		
32- Asbestos?	☐ **Yes**	☐ **No**
33- Silica (e.g., in sandblasting)?	☐ **Yes**	☐ **No**
34- Tungsten/cobalt (e.g., grinding or welding this material)?	☐ **Yes**	☐ **No**
35- Beryllium?	☐ **Yes**	☐ **No**
36- Aluminum?	☐ **Yes**	☐ **No**
37- Coal (for example, mining)?	☐ **Yes**	☐ **No**
38- Iron?	☐ **Yes**	☐ **No**
39- Tin?	☐ **Yes**	☐ **No**
40- Dusty environments?	☐ **Yes**	☐ **No**
41- Any other hazardous exposures?	☐ **Yes**	☐ **No**
42- Have you been absent from work for medical reasons in the past five years?	☐ **Yes**	☐ **No**
43- Have you ever required light or restricted duty? **List type and duration**	☐ **Yes**	☐ **No**
44- Have you ever had any occupational illness	☐ **Yes**	☐ **No**
If any of the above questions were answered "yes", please give details by referencing item number.		
Do you use :		
Tobacco (Cigarettes, Shisha, pipe, Vape, …….)	☐ **Yes**	☐ **No**
Alcohol	☐ **Yes**	☐ **No**
Substance	☐ **Yes**	☐ **No**

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

If yes, ☐ Current use ☐ Previous use Give details:		
Were you subjected to medical examinations (within the past 6 months)		☐ Yes ☐ No
2- If yes, please Specify :		
- Type of assessment: ----------		
- Purpose : ----------		
- Medical facility : ----------		
- Date of examination : ----------		
- Attach results if applicable. :----------		
Vaccination information :		
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA? ☐ Yes ☐ No		
PHYSICAL EXAMINATION		
General:		
Height (cm):	Weight (Kg):	BMI (consider hip:waist ratio)
Pulse rate: _____/min ☐ Regular ☐ Irregular Respiratory rate: _____/min	Blood pressure (mm Hg): Systolic: _____ Diastolic: _____	Temperature
Vision : Visual Acuity		
Unaided		Aided
Rt. Eye Distant: /20 Near: /20 Lt. Eye Distant: /20 Near: /20		Rt. Eye Distant: /20 Near: /20 Lt. Eye Distant: /20 Near: /20
(Tick the appropriate)		
Visual field		
Rt. Eye	Normal	Defective
Lt. Eye	Normal	Defective
Color vision: ☐ Normal	☐ Defective: Red-green/others	
Hearing :		
Whisper test (6 feet):		
RIGHT EAR PASS FAIL		LEFT EAR PASS FAIL
IF IMPAIRED, AUDIOMETRY SHOULD BE DONE		
Physical Findings: (Circle the appropriate)		

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

General Appearance	☐ Normal ☐ Abnormal
1- Pallor	☐ Normal ☐ Abnormal
2- Edema	☐ Normal ☐ Abnormal
3- Jaundice	☐ Normal ☐ Abnormal
4- Heart (Rhythm, sounds and murmurs)	☐ Normal ☐ Abnormal
5- Cognitive functions	☐ Normal ☐ Abnormal
6- Psychiatric (appearance, behavior, mood, thoughts and communication, and memory)	☐ Normal ☐ Abnormal
70- Mouth (Tongue and tonsils), teeth and gums	☐ Normal ☐ Abnormal
8- Ears, nose, throat	☐ Normal ☐ Abnormal
9- Thyroid exam	☐ Normal ☐ Abnormal
10- Lymph node	☐ Normal ☐ Abnormal
11- Eye exam	☐ Normal ☐ Abnormal
12- Lung and Chest (not including breast exam)	☐ Normal ☐ Abnormal
13- Abdomen (including organomegaly and hernia)	☐ Normal ☐ Abnormal
14- Urinary and genital system (not including pelvic exam)	☐ Normal ☐ Abnormal
15- Upper & lower extremities (strength and range of motion)	☐ Normal ☐ Abnormal
16- Spine	☐ Normal ☐ Abnormal
17- Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Normal ☐ Abnormal
18- Skin	☐ Normal ☐ Abnormal
Details of abnormality:----------	

Investigation

- Complete Urine Analysis

- HbA1C (only if known diabetic or abnormal urinalysis)

- Electrocardiogram (ECG) (above the age of 40 years only)

- Chest X-ray Post-Ant view (CXR-PA), (if clinically indicated).

- Audiometry (if clinically indicated)

- Spirometry

- BIOLOGICAL markers (for exposed above the permissible exposure limits only/ select applicable only)

Lead, Pb (µg/L)

Manganese, Mn (µg/L)

Cadmium, Cd (µg/L)

Note:

Copies of all investigation reports, X-ray reports , etc … should be attached to this form as part of the record.

FINAL DECISION OF PRE-PLACEMENT MEDICAL EXAMINATION REPORT

Job title: Name of the candidate:

Job code:

ID TYPE: NATIONAL PASSPORT ID NUMBER:

(Attach copy)

Fitness determination:

- FIT
- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:
- FIT with considerations
- FIT with restrictions.
- UNFIT

Name of health professional:

Signature:

Date:

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

المرفق ٩:

نموذج (WELDER MEDICAL SHEET)

EVERY 3 YEARS UNTIL AGE OF 50, THEN EVERY ONE YEAR.

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information		
Job Code:		Job Title: Date of joining current job:
Name in full (last, first, middle):	National ID: Iqama No	Employment: ☐ New hire ☐ Rehire
Date of birth:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married (IF Yes) ☐ Pregnant (If applicable) ☐ Yes ☐ No
Address & telephone No.	Email address:	

Health Questionnaire		
Do you currently have or previously had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.	☐ Yes	☐ No
2- Chest problems (asthma, Difficulty breathing, chest tightness, coughing or others)	☐ Yes	☐ No
3- Any neurological disorder e.g. (Severe/frequent headaches, Unsteadiness, Stroke, transient ischemic attacks, Tremors, sleep disorder, paralysis) or others	☐ Yes	☐ No
4- Epilepsy, Convulsions or loss of consciousness	☐ Yes	☐ No
5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/dislocations)	☐ Yes	☐ No
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)	☐ Yes	☐ No
7- Any Eye/vision problem or color blindness	☐ Yes	☐ No
8- Thyroid or other endocrine problem	☐ Yes	☐ No
9- Diabetes	☐ Yes	☐ No
10- Ear, nose, throat, Hearing difficulties, tinnitus, or Motion sickness requiring medication	☐ Yes	☐ No
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others	☐ Yes	☐ No
12- Urinary problem (Kidney, Bladder or Prostate)	☐ Yes	☐ No
13- Skin problem (e.g. allergies or dermatitis)	☐ Yes	☐ No
14- Infectious/contagious diseases	☐ Yes	☐ No
15- Tuberculosis	☐ Yes	☐ No
16- Digestive problem	☐ Yes	☐ No
17- Sleeping Disorders (OSA or Day Time Sleepiness)	☐ Yes	☐ No
18- Significant injuries	☐ Yes	☐ No
19- Cancer	☐ Yes	☐ No
20- Have you ever had any surgeries?	☐ Yes	☐ No
21- Have you ever been hospitalized?		
22- Suicide attempt	☐ Yes	☐ No

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23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)	☐ Yes	☐ No
24- Allergic reactions that interfere with your breathing	☐ Yes	☐ No
25- Claustrophobia	☐ Yes	☐ No
26 Smelling	☐ Yes	☐ No
27- Pulmonary symptoms (cough, wheezing, etc)	☐ Yes	☐ No
28- Eye irritation	☐ Yes	☐ No
29- Any health problem, which requires visits to the doctor, or for which you take regular drugs? **If any of the above questions were answered "yes", please give details by referencing the item number.** **Provide information regarding diagnosis and treatment, including dates of treatment.**	☐ Yes	☐ No
Occupational history:		
30- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? **IF YES,** **Industry: ----------** **Job title: ----------** **Employer address: ----------** **Dates of employment: ----------** **Type of exposure……** **Duration of exposure…….** **Refer to Occupational Exposure questionnaire**	☐ Yes	☐ No
31- Have you ever received worker's disability/ compensation?	☐ Yes	☐ No
Have you ever worked with any of the materials, or under any of the conditions listed below?		
32- Asbestos?	☐ Yes	☐ No
33- Silica (e.g., in sandblasting)?	☐ Yes	☐ No
34- Tungsten/cobalt (e.g., grinding or welding this material)?	☐ Yes	☐ No
35- Beryllium?	☐ Yes	☐ No
36- Aluminum?	☐ Yes	☐ No
37- Coal (for example, mining)?	☐ Yes	☐ No
38- Iron?	☐ Yes	☐ No
39- Tin?	☐ Yes	☐ No
40- Dusty environments?	☐ Yes	☐ No
41- Any other hazardous exposures?	☐ Yes	☐ No
42- Have you been absent from work for medical reasons in the past five years?	☐ Yes	☐ No
43- Have you ever required light or restricted duty? **List type and duration**	☐ Yes	☐ No
44- Have you ever had any occupational illness	☐ Yes	☐ No
If any of the above questions were answered "yes", please give details by referencing item number.		
Do you use :		
Tobacco (Cigarettes, Shisha, pipe, Vape, …….)	☐ Yes	☐ No

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Alcohol	☐ Yes	☐ No
Substance	☐ Yes	☐ No
If yes, ☐ Current use ☐ Previous use **Give details:**		
Were you subjected to medical examinations (within the past 6 months)	☐ Yes	☐ No
2- If yes, please Specify:		
- Type of assessment: ----------		
- Purpose: ----------		
- Medical facility: ----------		
- Date of examination: ----------		
- Attach results if applicable. :----------		
Vaccination information:		
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA? ☐ Yes ☐ No		
PHYSICAL EXAMINATION		
General:		

Height (cm):	**Weight (Kg):**	**BMI** (consider hip: waist- to-hip ratio as best alternative)
Pulse rate: _____/min ☐ Regular ☐ Irregular **Respiratory rate: _____/min**	**Blood pressure (mm Hg):** **Systolic: _____ Diastolic: _____**	**Temperature**

Vision : Visual Acuity	
Unaided	**Aided**
Rt. Eye **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**	**Rt. Eye** **Distant: /20 Near: /20** **Lt. Eye** **Distant: /20 Near: /20**
(Tick the appropriate)	

Visual field		
Rt. Eye	**Normal**	**Defective**
Lt. Eye	**Normal**	**Defective**
Color vision: ☐ Normal	☐ Defective: Red-green/others	
Hearing :		
Whisper test (6 feet) :		

RIGHT EAR	**PASS**	**FAIL**	**LEFT EAR**	**PASS**	**FAIL**
IF IMPAIRED, AUDIOMETRY SHOULD BE DONE					
Physical Findings: **(Circle the appropriate)**					

General Appearance	☐ Normal ☐ Abnormal

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

1- Pallor	☐ Normal ☐ Abnormal
2- Edema	☐ Normal ☐ Abnormal
3- Jaundice	☐ Normal ☐ Abnormal
4- Heart (Rhythm, sounds and murmurs)	☐ Normal ☐ Abnormal
5- Cognitive functions	☐ Normal ☐ Abnormal
6- Psychiatric (appearance, behavior, mood, thoughts and communication, and memory)	☐ Normal ☐ Abnormal
7- Mouth (Tongue and tonsils), teeth and gums	☐ Normal ☐ Abnormal
8- Ears, nose, throat	☐ Normal ☐ Abnormal
9- Thyroid exam	☐ Normal ☐ Abnormal
10- Lymph node	☐ Normal ☐ Abnormal
11- Eye exam	☐ Normal ☐ Abnormal
12- Lung and Chest (not including breast exam)	☐ Normal ☐ Abnormal
13- Abdomen (including organomegaly and hernia)	☐ Normal ☐ Abnormal
14- Urinary and genital system (not including pelvic exam)	☐ Normal ☐ Abnormal
15- Upper & lower extremities (strength and range of motion)	☐ Normal ☐ Abnormal
16- Spine	☐ Normal ☐ Abnormal
17- Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Normal ☐ Abnormal
18- Skin	☐ Normal ☐ Abnormal
Details of abnormality:----------	

Investigation

- Complete Urine Analysis
- HbA1C (only if known diabetic or abnormal urinalysis)
- Electrocardiogram (ECG) (above the age of 40 years only)
- Chest X-ray Post-Ant view (CXR-PA), (if clinically indicated).
- Audiometry (if clinically indicated or as baseline for applicable jobs)
- Spirometry
- Complete blood count
- BIOLOGICAL markers (for candidate with previous exposure to establish basle line/select applicable only)

Lead, Pb (µg/L)

Manganese, Mn (µg/L)

Cadmium, Cd (µg/L)

Note:

Copies of all investigation reports, X-ray reports, etc. … should be attached to this form as part of the record.

FINAL DECISION OF PRE-PLACEMENT MEDICAL EXAMINATION REPORT

Job title: Name of the candidate:

Job code:

ID TYPE: NATIONAL PASSPORT ID NUMBER:

(Attach copy)

Fitness determination:

- FIT
- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:
- FIT with considerations
- FIT with restrictions.
- UNFIT

Name of health professional:

Signature:

Date:

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

المرفق ١٠:
نموذج (MINING AND UNDERGROUND MEDICAL SHEET)

SEE THE APPENDIX FOR
CANDIDATE'S PERSONAL DECLARATION

Personal information		
Job Code:		**Job Title:**
Name in full (last, first, middle):	**National ID:** **Iqama No**	**Employment:** ☐ New hire ☐ Rehire
Date of birth:	**Gender:** ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married (IF Yes) ☐ Pregnant (If applicable) ☐ Yes ☐ No
Address & telephone No.	**Email address:**	
Health Questionnaire		
Do you now have or had any of the following conditions?		
1- Cardiovascular problems (High blood pressure, palpitation, Heart/blood vessel disease or fainting) or others.		☐ Yes ☐ No
2- Chest problems (asthma, Difficulty breathing, chest tightness or others)		☐ Yes ☐ No
3- Any neurological disorder e.g. (Severe/frequent headaches, Unsteadiness, Stroke, transient ischemic attacks, Tremors, sleep disorder, paralysis) or others		☐ Yes ☐ No
4- Epilepsy, Convulsions or loss of consciousness		☐ Yes ☐ No
5- Musculoskeletal problems (Joint problems, Restricted mobility, Back problems, Fractures/dislocations)		☐ Yes ☐ No
6- Psychological disorders e.g. (Anxiety, depression, psychosis, bipolar, Phobia)		☐ Yes ☐ No
7- Any Eye/vision problem or color blindness		☐ Yes ☐ No
8- Thyroid or other endocrine problem		☐ Yes ☐ No
9- Diabetes		☐ Yes ☐ No
10- Ear, nose, throat, Hearing difficulties, tinnitus, or Motion sickness requiring medication		☐ Yes ☐ No
11- Blood disorders/ anemia (e.g. Sickle cell anemia) or others		☐ Yes ☐ No
12- Urinary problem (Kidney, Bladder or Prostate)		☐ Yes ☐ No
13- Skin problem (e.g. allergies or dermatitis)		☐ Yes ☐ No
14- Infectious/contagious diseases		☐ Yes ☐ No
15- Tuberculosis		☐ Yes ☐ No
16- Digestive problem		☐ Yes ☐ No
17- Sleeping Disorders (OSA or Day Time Sleepiness)		☐ Yes ☐ No

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18- Significant injuries	☐ **Yes**	☐ **No**
19- Cancer	☐ **Yes**	☐ **No**
20- Have you ever had any surgeries?	☐ **Yes**	☐ **No**
21- Have you ever been hospitalized?	☐ **Yes**	☐ **No**
22- Suicide attempt	☐ **Yes**	☐ **No**
23- Autoimmune/connective tissue diseases (e.g. Rheumatoid arthritis)	☐ **Yes**	☐ **No**
24- Any health problem, which requires visits to the doctor, or for which you take regular drugs? **If any of the above questions were answered "yes", please give details by referencing the item number.** **Provide information regarding diagnosis and treatment, including dates of treatment.**	☐ **Yes**	☐ **No**
Occupational history:		
25- Have you ever been exposed to fumes, dust, chemicals, loud noise, radiation, or other hazards at work or elsewhere? **IF YES,** **Industry: ----------** **Job title: ----------** **Employer address: ----------** **Dates of employment: ----------** **Type of exposure……** **Duration of exposure…….** **Refer to Occupational Exposure questionnaire**	☐ **Yes**	☐ **No**
26- Have you ever received worker's disability/ compensation?	☐ **Yes**	☐ **No**
27- Have you been absent from work for medical reasons in the past five years?	☐ **Yes**	☐ **No**
28- Have you ever required light or restricted duty? **List type and duration**	☐ **Yes**	☐ **No**
29- Have you ever had any occupational illness	☐ **Yes**	☐ **No**
If any of the above questions were answered "yes", please give details by referencing item number.		
Do you use :		
Tobacco (Cigarettes, Shisha, pipe, Vape, …….)	☐ **Yes**	☐ **No**
Alcohol	☐ **Yes**	☐ **No**
Substance	☐ **Yes**	☐ **No**
If yes, ☐ **Current use** ☐ **Previous use** **Give details:**		
Were you subjected to medical examinations (within the past 6 months)	☐ **Yes**	☐ **No**
2- If yes, please Specify :		
- Type of assessment: ----------		
- Purpose : ----------		

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

- Medical facility : ----------		
- Date of examination : ----------		
- Attach results if applicable. :----------		
Vaccination information :		
PHYSICAL EXAMINATION		
General:		
Height (cm):	Weight (Kg):	BMI (consider waist-to-hip ratio as best alternative)
Pulse rate: _____/min ☐ Regular ☐ Irregular Respiratory rate: _____/min	Blood pressure (mm Hg): Systolic: _____ Diastolic: _____	Temperature
Vision : Visual Acuity		
Unaided		Aided
Rt. Eye Distant: /20 Near: /20 Lt. Eye Distant: /20 Near: /20		Rt. Eye Distant: /20 Near: /20 Lt. Eye Distant: /20 Near: /20
(Tick the appropriate)		
Visual field		
Rt. Eye	Normal	Defective
Lt. Eye	Normal	Defective
Color vision: ☐ Normal	☐ Defective: Red-green/others	
Hearing:		
Whisper test (6 feet) :		
RIGHT EAR PASS FAIL	LEFT EAR PASS FAIL	
IF IMPAIRED, AUDIOMETRY SHOULD BE DONE		
Physical Findings: (Circle the appropriate)		
General Appearance		☐ Normal ☐ Abnormal
1- Pallor		☐ Normal ☐ Abnormal
2- Edema		☐ Normal ☐ Abnormal
3- Jaundice		☐ Normal ☐ Abnormal
4- Heart (Rhythm, sounds and murmurs)		☐ Normal ☐ Abnormal
5- Cognitive functions		☐ Normal ☐ Abnormal
6- Psychiatric (appearance, behavior, mood, thoughts and communication, and memory)		☐ Normal ☐ Abnormal
7- Mouth/teeth		☐ Normal ☐ Abnormal

لائحة فحوصات اللياقة المهنية والأمراض غير المعدية .. تتمة

8- Ears, nose, throat	☐ Normal ☐ Abnormal
9- Lung and Chest (not including breast exam)	☐ Normal ☐ Abnormal
10- Abdomen (including hernia)	☐ Normal ☐ Abnormal
11- Urinary and genital system (not including pelvic exam)	☐ Normal ☐ Abnormal
12- Upper & lower extremities (strength and range of motion)	☐ Normal ☐ Abnormal
13- Spine	☐ Normal ☐ Abnormal
14- Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Normal ☐ Abnormal
15- Skin	☐ Normal ☐ Abnormal
Details of abnormality:----------	

Details of abnormality:----------

Investigation

- Chest X-ray Post-Ant view (CXR-PA).
- Spirometry and respiratory fit testing
- Audiometry

Note:

Copies of all investigation reports, X-ray reports , etc … should be attached to this form as part of the record.

FINAL DECISION OF END OF SERVICE MEDICAL EXAMINATION REPORT

Job title: **Name of the candidate:**
Job code:
ID TYPE: NATIONAL PASSPORT ID NUMBER:
(Attach copy)
Medical opinion based on:
- FIT

- All other fitness determinations should be referred to Occupational Medicine Specialist/Consultant, including:

- FIT with considerations

- Fit with restrictions.

- UNFIT

Name of Heath Professional :
Signature:
Date:

CANDIDATE'S PERSONAL DECLARATION

I, the undersigned, hereby affirm that I have given true and complete information to the best of my knowledge regarding my medical history. I understand and accept that if, after having been employed, any false statement or misrepresentation, or omitted material information will constitute a valid reason for my immediate employment termination by my employer without termination benefits.

I, the undersigned, hereby authorize the release of the information I have provided herein, and the results of any required medical examination, including the opinions and evaluations of the examining physicians, to the examining healthcare institute and their employees and authorized agents.

I, the undersigned, do voluntarily agree to release and hold my employer and their employees and authorized agents harmless from any claim, demand or cause of action for damages arising from the review and release of my medical information for the purpose of consideration for employment or aggrigate data analysis for epidemiological studies purposes.

Name of candidate……. **Signature……**
Date …….