لائحة فحوصات اللياقة المهنية والكشف عن الأمراض غير المعدية

مقدمة:

انطلاقاً من مبادئ وأهداف السياسة الوطنية للسلامة والصحة المهنية الصادرة بقرار مجلس الوزراء رقم 328 وتاريخ 1442/6/13هـ بتطبيق مبدأ الوقاية المرتبط مباشرة بحماية وحفظ وتعزيز الصحة البدنية والعقلية والاجتماعية للعاملين ،و تقييم ومنع الأخطار من مصادرها للحد من الإصابات والأمراض المهنية من خلال تطوير التشريعات والأنظمة واللوائح والبرامج وأي أدوات تنظيمية، واستناداً على صلاحيات واختصاصات المجلس الوطني للسلامة والصحة المهنية الواردة بالمادة (الثالثة) من تنظيم المجلس الصادر بقرار مجلس الوزراء رقم 379 وتاريخ 1443/07/07هـ، ووفقا لأحكام المواد الحادية والثلاثون بعد المائة مكرر ،و الثالثة والأربعون بعد المائة ، والسابعة والثمانون بعد المائة من نظام العمل الصادر بالمرسوم الملكي رقم م/51 بتاريخ 23 / 8 / 1426 هـ وتعديلاته ،و ما يرتبط بها من الزامية إجراء الفحوصات الطبية ، فقد تم إعداد هذه اللائحة بالتعاون مع الجهات والهيئات الحكومية وبالتشاور مع ممثلي أصحاب العمل ، وممثلي العمال ،وبما يتطابق مع أفضل المعايير و الممارسات المحلية والعالمية للفحوصات الطبية للياقة المهنية مع متطلبات منظمة العمل الدولية ومنظمة الصحة العالمية ذات الصلة، لتوضيح الآليات المتعلقة بالفحوصات الطبية للياقة المهنية لجميع المهن في سوق العمل السعودي ، وذلك بهدف رصد ومتابعة صحة الأفراد ، وتعزيز الصحة المهنية من خلال الفحص ما قبل التعيين، والفحص الدوري للعاملين مما يساهم في الحد من حوادث العمل والأمراض المهنية وتحسين بيئات العمل في المملكة العربية السعودية.

المادة الأولى:

يقصد بالكلمات والمصطلحات الواردة أدناه -أينما وردت في هذه اللائحة - المعاني الموضحة أمام كل منها، ما لم يقتض سياق النص خلاف ذلك:

- **اللائحة:** اللائحة الوطنية لفحوصات اللياقة المهنية.
- **المجلس:** المجلس الوطني للسلامة والصحة المهنية.
- **الوزير:** وزير الموارد البشرية والتنمية الاجتماعية.
- **المسؤول الأول:** الوزير، المحافظ أو الرئيس التنفيذي، الرئيس المدير، أو الأمين المشرف، أو من يقوم مقامهم.
- **صاحب العمل :** كل شخص طبيعي أو اعتباري يشغّل عاملًا أو أكثر مقابل أجر او من يفوضه بمنشأت القطاع الخاص .
- **العامل:** كل شخص طبيعي- ذكراً أو أنثى - يعمل لمصلحة صاحب عمل وتحت إدارته أو إشرافه مقابل أجر، ولو كان بعيدًا عن نظارته.
- **الموظف:** كل من يشغل وظيفة مدنية عامة في الدولة أو يمارس مهامها أياً كانت طبيعة عمله أو اسم وظيفته سواء كان ذلك عن طريق التعيين أو التعاقد بصفة دائمة أو مؤقتة.
- **المنشأة:** كل مشروع يديره شخص طبيعي أو اعتباري، يشغل عاملا أو أكثر، مقابل أجر أياً كان نوعه.
- **اللياقة المهنية:** أن يكون الفرد مؤهلاً لأداء المهام المهنية والوظيفية المطلوبة بفعالية ،ودون تعريض صحته أو سلامة الآخرين للخطر، ويشمل ذلك التأهُل الصحي والعقلي والنفسي.
- **السلامة والصحة المهنية:** حماية العامل/الموظف من أي خطر مرتبط بعمله يشكل تهديداً لسلامته أو صحته، ويشمل ذلك الصحة البدنية والعقلية والاجتماعية.
- **متابعة اللياقة المهنية:** تحديد التغيرات في الحالة الصحية نتيجة مزاولة أنشطة ومهام تؤدي للتعرض لمواد معينة في موقع العمل، من خلال طبيب متخصص بالطب المهني.
- **الفحص الطبي المهني:** المسوحات الاستقصائية البحثية والفحص الاكلينيكي لغرض الوقاية من الإصابة بالأمراض المهنية.
- **الطبيب المهني:** هو الطبيب المتخصص في الطب المهني (Occupational Medicine)، وهو فرع من فروع الطب يُعنى بصحة وسلامة العاملين في أماكن العمل، ويهدف إلى الوقاية من الأمراض والإصابات المرتبطة بالمهنة وتشخيصها وعلاجها.
- **المرض المهني:** المرض الذي ينشأ بسبب العمل في مهن أو أنشطة اقتصادية تسبب هذا المرض، ولا يرجع إلى عوامل خارجة عن عمله، بشرط أن يكون هذا المرض وارداً في جدول الأمراض المهنية والمحددة فيه هذه الأمراض على سبيل الحصر.
- **المهنة:** هي عمل أو وظيفة يقوم بها الفرد بشكل منتظم، وتتطلب مهارات ومعرفة متخصصة يتم اكتسابها من خلال التعليم أو التدريب، وتهدف إلى تقديم خدمة أو عمل معين مقابل أجر أو دخل.
- **الجهة:** أي وزارة أو جهاز حكومي أو هيئة أو مصلحة أو مؤسسة عامة أو صندوق أو ما في حكمها، وأي جهاز مستقل ذي شخصية معنوية عامة.

- **المهن وبيئة العمل ذات المخاطر العالية:** المهن التي قد يتعرض أصحابها، بشكل دائم أو جزئي، حسب مدة التعرض والتكرار، عند أدائهم لمهام العمل لأنشطة وعمليات عالية المخاطر - على سبيل المثال لا الحصر، مواقع البناء والانشاءات أو العمل في خدمات النقل أو التعامل مع مواد عالية الخطورة مثل المواد الكيميائية او الاشعاعات المؤينة، مما يرفع من احتمالات الإصابة بمرض مهني أو وقوع حوادث قد تتسبب في الوفاة أو تسفر عن إصابات بالغة أو عجز.
- **التدابير الوقائية:** جميع التدابير الوقائية التي يتم تنفيذها للحد من المخاطر والخسائر المتوقعة.

المادة الثانية:

تهدف هذه اللائحة إلى توفير إطار شامل لتقييم اللياقة الصحية والنفسية للموظفين/العاميلن لضمان قدرتهم على أداء مهامهم الوظيفية بكفاءة وأمان بما يتماشى مع المعايير الوطنية وأفضل الممارسات الدولية والتي تتمثل في:

١. الحد من إصابات وحوادث العمل والأمراض المهنية.
٢. تعزيز اللياقة البدنية والنفسية للعاملين/الموظفين.
٣. ضمان قدرة العاملين/الموظفين على أداء مهامهم بأمان وكفاءة
٤. التعريف بآلية الفحوصات الطبية ماقبل التعيين/التوظيف والدورية لمزاولي المهن ذات المخاطر العالية.
٥. توحيد نماذج الفحص الطبي قبل التعيين/التوظيف والفحص الدوري والفحص الاستثنائي التي تتناسب مع كل مهنة وتوفير قواعد بيانات شاملة عن الحالة الصحية لجميع العاملين/الموظفين.
٦. تحسين الامتثال للمعايير واللوائح المحلية والاتفاقيات الدولية في مجال السلامة والصحة المهنية.

المادة الثالثة:

١. يسري تطبيق هذه اللائحة على جميع الموظفين و العاملين بالجهات العامة ، ومنشآت القطاع الخاص والقطاع غير الربحي وفقا لما يلي:

أ. المرشحون الجدد قبل التعيين.
ب. العاملين/الموظفين على رأس العمل في الحالات التالية:

١) بعد وقوع اصابة مهنية
٢) عند العودة من إجازة طبية طويلة
٣) عند وجود شكوك على قدرة العامل / الموظف على أداء عمله
٤) في حال تطلبت الوظيفة / المهنه فحص طبي دوري وفقا للنماذج المعتمدة والملحقة بهذه اللائحة
٥) في حال تغيير مهنة العامل / الموظف.
٦) في حال حدوث تغيير في بيئة العمل.
٧) في حال استخدام معدات أو آلات أو أجهزة جديدة.

ج. عند التقاعد من العمل في حالة التعرض لمواد ذات فترة كمون طويلة خلال فترة العمل مثل: مادة الاسبستوس

٢. لايسري تطبيق هذه اللائحة على الفحوصات الطبية خارج نطاق الوظيفة/ المهنة.

المادة الرابعة:

يلتزم المسؤول الأول في الجهات الحكومية /القطاع العام المدني وصاحب العمل في منشآت القطاع الخاص والغير ربحي بما يلي:

١. التحقق و التأكد من إجراء فحوصات اللياقة المهنية ومتابعة العاملين/الموظفين لديه وفق النماذج المعتمدة والمهن المحددة لهم، واتخاذ الترتيبات اللازمة لتمكين العامل/الموظف من ذلك.
٢. توفير الموارد اللازمة لإجراء الفحوصات للعاملين/الموظفين لديه.
٣. اشعار الطبيب المختص في الطب المهني بأي تعرضات أو مخاطر قد تؤثر على سلامة وصحة العامل/الموظف أثناء مزاولة العمل.
٤. التأكد من حصول العامل على المراقبة الصحية المناسبة لمخاطر الصحة والسلامة التي يتعرض لها في العمل.

٥. العمل على إنشاء سجلاتاحكام صحية ضمن معايير نظام حماية البيانات الشخصية تتضمن مختلف الوثائق التي تحتوي على التاريخ الطبي المهني للعامل/الموظف في مكان عمله ومشاركتها مع أمانة المجلس من خلال الوسيلة التي يقرها المجلس.
٦. دعم الامتثال لأحكام اللائحة.
٧. اتخاذ كافة الإجراءات والتدابير لتنظيم العمل وفق متطلبات اللائحة.
٨. بذل الجهد لإيجاد عمل بديل إذا كانت وظيفة العامل محظورة طبيًا مع مراعاة الحالات التالية:

أ. في حالة حدوث تغييرات في الحالة الصحية للموظف أو تطور جديد في القيود الطبية، يجب على صاحب العمل إعادة النظر في العمل البديل المقدم وتحديثه بما يتناسب مع الوضع الصحي لضمان نجاح الموظف في العمل الجديد مع الحفاظ على صحته وسلامته.
ب. إذا كان الموظف غير قادر على أداء مهام العمل البديل بشكل كامل بسبب القيود الطبية، يجب على صاحب العمل توفير التعديلات اللازمة على ظروف العمل، مثل ساعات العمل المرنة أو العمل الجزئي أو أي ترتيبات أخرى تضمن استمرار الموظف في بيئة آمنة وملائمة.
ج. إذا تحسنت حالة الموظف الصحية بمرور الوقت وأصبح قادرًا على العودة إلى العمل الأصلي، يجب على صاحب العمل إجراء تقييم شامل لاستعادة الموظف لوظيفته الأصلية بما يتماشى مع حالته الصحية الحالية.

المادة الخامسة:

يلتزم الموظفين والعاملين بمايلي:

١. إجراء فحوصات اللياقة المهنية التي تطلبها منهم الجهة او المنشأة ، وفقا لمتطلبات هذه اللائحة ووفق النماذج المعتمدة والمهنة التي سيقوم بمزاولتها والاستجابة لمتطلباتها بالتنسيق مع جهة العمل.

٢. الإفصاح عن الأعراض والإصابات والأمراض المهنية وتقديم أي معلومات صحية ضرورية وفقاً للنموذج المعتمد.
٣. إشعار الجهة أو صاحب المنشأة أو من يمثله عن أي أنشطة أو عيوب يمكن أن تؤثر على سلامته أو الآخرين من حوله.
٤. إبلاغ الجهات ذات العلاقة عن أي تجاوزات من قبل المنشآت في تطبيق متطلبات اللائحة.

المادة السادسة:

يتم اختيار نموذج فحص اللياقة المهنية للعامل/ الموظف وفق المعايير التالية:

١. العمل الفعلي.
٢. الوصف الوظيفي.
٣. نوعية المواد أو العوامل الفيزيائية أوالكميائية أو الحيوية التي يتعرض لها.
٤. طريقة تعرضه للمواد.
٥. مستوى تعرضه للمواد أو العوامل الفيزيائية أوالكميائية أو الحيوية.
٦. مدة التعرض للمواد أو العوامل الفيزيائية أوالكميائية أو الحيوية.
٧. تطبيق التدابير الوقائية وتوفُّر المعدات الخاصة المطابقة للمواصفات القياسية الصادرة من الهيئة السعودية للمواصفات والمقاييس والجودة فيما يخص السلامة والصحة المهنية لتقليل تعرضه للمواد وفق الأنظمة ذات العلاقة ومراقبة التأثيرات الصحية الضارة.

المادة السابعة:

لا يجوز استخدام فحص اللياقة المهنية بديلاً عن تنفيذ تدابير السيطرة والتحكم الفعّالة الفردية والجماعية إلا في الحالات التالية:

١. لمعرفة مدى فعالية تدابير التحكم الخاصة بمزاولي المهنة (تقييم مستويات التعرض).
٢. لتطبيق تدابير تحكم جديدة أكثر فاعلية إذا دعت الحاجة لذلك.

المادة الثامنة :

تتمثل أنواع الفحوصات الطبية للياقة المهنية وفق الاتي:

١. الفحص الطبي العام:

أ. تقييم الوظائف الحيوية
ب. فحص الامراض المزمنة

٢. الفحص التخصصي الإضافي حسب طبيعة المهنة وفقا للنماذج المعتمدة
٣. الفحص النفسي لضمان الصحة النفسية والعقلية.

المادة التاسعة:

تكون الية تنفيذ الفحوصات وفق الاتي:

١. **الفحص الطبي قبل التعيين / التوظيف:** يجري هذا الفحص على جميع المرشحين للوظائف/ المهن، ويشمل على تحليل التاريخ الطبي وتاريخ التعرض للظروف المهنية، وفقاً للنماذج المعتمدة حسب طبيعة المهنة / الوظيفة.
٢. **الفحص الطبي الدوري:** يُجرى على فترات زمنية منتظمة وفقاً لمتطلبات كل مهنة/ وظيفة، ونوع ومستوى المخاطر الصحية المتعرض لها، وقد تكون هذه الفحوصات الدورية "مقيدة" قانونياً مثل العمل في الطيران، الغوص، تصنيع وخدمات الأطعمة، الإطفاء، حمل الأسلحة والتعامل مع المتفجرات والمواد المشعة وغيرها.
٣. **الفحص الطبي الاستثنائي:** يجري في الحالات الطارئة مثل وقوع حادث أو تغير ملحوظ في الأداء أو في حال ملاحظة الطبيب المختص لعلامات مبكرة لأمراض مهنية محددة أو وجود مجموعة من الحالات المتشابهة والناتجة عن التعرض المحتمل للمواد السامة.

المادة العاشرة:

يتكون الفحص الطبي للياقة المهنية من ثلاث برامج متكاملة على النحو التالي:

١. **فحوصات اللياقة المهنية الاجبارية:** يتم إجراؤها بشكل دوري ومنتظم وفقاً لمتطلبات مزاولة المهنة ويشتمل على استبيان اللياقة المهنية الاجباري المتضمن على العلامات الحيوية وفحوصات الحواس (فحص العقل، السمع، والبصر) وفحوصات التعرض الى أخطار محددة مثل التعرض الى المواد الكيمائية او العوامل الفيزائية (مثل الضوضاء ، البرودة، الحرارة، ..الخ) أو أي أخطار أخرى مثل خطر العمل بالمرتفعات أو الأماكن الضيقة ان وجدت، ويعد وثيقة قانونية ملزمة.
٢. **فحوصات اللياقة المهنية الخاصة:** تُحدَّد بناءً على تقييم المخاطر أو ظروف بيئات العمل أو التي يتم إضافتها من طرف الطبيب المختص بالطب المهني بناءً على مؤشرات صحية أخرى ومنها:
   أ. اختبارات وظائف الرئة وملائمة الكمامات.
   ب. اختبارات الطاقة البدنية الهوائية "الايروبيك".
   ج. اختبارات المواد المخدرة.
   د. اختبارات تفرضها الوظيفة (مثل الفحوصات المرتبطة بالامراض المعدية).
٣. **فحوصات اللياقة المهنية حسب التعرض أوالعمر:** يجب على المنشأة إضافة الفحوصات حسب التعرض أوالعمر إلى قائمة الفحوصات المطلوبة للمهنة وتحديث ذلك في سياستها الداخلية، وذلك بما لا يؤثر على قائمة الفحوصات الإجبارية والخاصة.
٤. **الفحوصات الاختيارية:** يجوز للجهة المشرفة أو المرخصة للمجال الاقتصادي أو المسؤول الأول أو صاحب العمل، وضع سياسة خاصة تتعلق بالفحوصات والاختبارات التي تتناسب مع طبيعة العمل بالمهنة داخل المنشأة، بما في ذلك فحوصات المخدرات، بما لا يتعارض مع هذه اللائحة أو الأنظمة والتشريعات والسياسات واللوائح الوطنية ذات العلاقة.

٥. **يتم الترميز اللوني لمستويات الفحوصات كما يلي:**

(اللون البرتقالي) فحص اللياقة المهنية الاجبارية	(اللون الأخضر) فحص اللياقة المهنية الخاصة	(اللون الأزرق) فحص اللياقة المهنية حسب التعرض أوالعمر

المادة الحادية عشرة:

تُجرى فحوصات اللياقة المهنية للمهن ذات المخاطر العالية بما يتوافق مع الاشتراطات المحددة في الدليل الإجرائي لتنظيم العمل بالمهن ذات المخاطر العالية، وتنقسم هذه الفحوصات إلى الفئات التالية:

١. الفحص الطبي للياقة المهنية للمهن الخطرة.
٢. الفحص الطبي للياقة المهنية للمهن المقيدة.

- تخضع الفحوصات الطبية للياقة المهنية المضمنة في نماذج فحوصات اللياقة المهنية لمزاولي المهن ذات المخاطر العالية إلى الترميز اللوني لمستويات الفحوصات كما هو موضح في الفقرة الرابعة من المادة العاشرة.

المادة الثانية عشرة:

يتم التعامل مع نتائج الفحوصات وفق الاتي:

١. عند الانتهاء من اجراء الفحص الطبي قبل التعيين/التوظيف تكون النتيجة وفقا لما يلي:

أ. لائق صحيا ويسمح له بمزالة المهنة / الوظيفة المرشح لها .
ب. لائق صحيا مع تحديد القيود او الاعتبارات المطلوب الالتزام بها عند مزاولة المهنة المرشح لها بما في ذلك المدة الزمنية.
ج. غير لائق صحيا لا يسمح له بمزاولة المهنة / الوظيفة المرشح لها (تحدد المدة الزمنية).

٢. في حالة عدم تحقيق متطلبات اللياقة المهنية بعد الفحص الدوري، يُمنع العامل/الموظف من الاستمرار في مزاولة مهنته ويجب على الإدارة المشرفة اتخاذ الإجراءات اللازمة لتغيير مهنته، ما لم يتوفر هناك دليل كافٍ يثبت قدرته على أداء مهامه الوظيفية بكفاءة ودون مخاطر على نفسه أو على الآخرين، من خلال فحوصات إضافية او توصيات يحددها طبيب مهني مختص، أو لجنة مكونة من ثلاثة أطباء متخصصين في الطب المهني على الأقل، كما يحق لصاحب العمل استثناء بعض الحالات شريطة عدم تأثر سلامة وصحة العامل / الموظف بعد موافقة اللجنة والعامل.

المادة الثالثة عشرة:

١. يحق للعامل /الموظف الاعتراض على نتائج الفحوصات خلال 30 يوماً من التبلغ بنتيجة الفحص.
٢. تشكل لجنة مراجعة مستقلة في أمانة المجلس من ذوي الاختصاص في الطب المهني والاختصاصات ذات العلاقة للنظر في الاعتراضات، على أن تكون مدة إصدار القرار خلال 15 يوماً.

المادة الرابعة عشرة:

يجب أن يُجرى الفحص الطبي للياقة المهنية بواسطة فريق مختص تحت إشراف طبيب مختص في الطب المهني معتمد من هيئة التخصصات الصحية ومسجل من أمانة المجلس الوطني للسلامة والصحة المهنية.

المادة الخامسة عشرة:

يلتزم الطبيب المختص في الطب المهني بإجراء الفحوصات الطبية قبل التعيين / التوظيف، والفحوصات الدورية، والفحوصات الاستثنائية للعاملين والموظفين، وفقا لنماذج فحص اللياقة المهنية المعتمدة المرفقة باللائحة.

المادة السادسة عشرة:

١. تُعتبر جميع السجلات الطبية وثائق سرية ولايجوز الاطلاع عليها إلا من قبل مختصي الرعاية الصحية في المنشأة أو هيئات الفحص الطبي، ويحق للعاملين/الموظفين الاطلاع على المعلومات الواردة في سجلات تقييم صحتهم الشخصية ويمكنهم طلب نسخة منها وذلك بما يتوافق مع أحكام نظام حماية البيانات الشخصية.
٢. يجوز نقل السجلات الطبية للعاملين/ الموظفين عند الانتقال الى منشأة اخرى بعد الحصول على موافقة كتابية أو إلكترونية منهم.

٣. تُعتمد إجراءات وتدابير صارمة لضمان أمان المعلومات والتكنولوجيا وحمايتها لمنع الفقدان أو سوء الاستخدام أو التعديل أو الوصول غير المصرح به إلى النظام الإلكتروني وذلك وفقاً لضوابط سياسة حوكمة البيانات الوطنية والتنظيمات ذات العلاقة الصادرة عن الهيئة السعودية للبيانات والذكاء الاصطناعي.
٤. لصاحب العمل الحق في معرفة قرار الطبيب حول القدره على العمل "لا غير" وتشمل (قادر على العمل، غير قادر على العمل او قادر مع قيود او اعتبارات مع ذكر القيود او الاعتبارت الملائمة ان وجدت)

المادة السابعة عشرة:
تغطي اللائحة العاملين والموظفين داخل المملكة.

المادة الثامنة عشرة:
في حال مخالفة أحكام هذه اللائحة تطبق الجزاءات والعقوبات الواردة في الأنظمة واللوائح والقرارات ذات الصلة.

المادة التاسعة عشرة:

تنشر هذه اللائحة في الجريدة الرسمية، ويُعمل بها من تاريخ نشرها وفقاً لإدارة المرحلة الإنتقالية للامتثال لمتطلبات منظومة اللياقة المهنية المضمنة بقرار اعتماد هذه اللائحة.

المادة العشرون:

يُعِد المجلس دليلًا يتضمن الأحكام التفصيلية والضوابط المتعلقة بتعبئة النماذج وحفظ السجلات والبيانات واعتماد مزودي ومقدمي الخدمات أفراد/منشآت إضافة إلى جميع الأحكام والقواعد ذات الصلة بهذه اللائحة.

Introduction

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-employmentand 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

The terms and phrases mentioned below, wherever they appear in this regulation, shall have the meanings indicated next to each of them, unless the context of the text requires otherwise :

- **Regulation :** The National Regulation for Occupational Fitness Examinations.
- **Council :** The National Council for Occupational Safety and Health.
- **Minister :** The Minister of Human Resources and Social Development.
- **First Responsible :** The Minister, Governor, CEO, Managing Director, Secretary Supervisor, or anyone acting on their behalf.
- **Employer:** Any natural or legal person who employs one or more workers in exchange for wages, or their authorized representative in private sector establishments.
- **Worker :** Any person working for the benefit of an employer and under their management or supervision for wages, even if they are away from their oversight.
- **Employee :** Anyone holding a public civil position in the state or in the private sector or performing its duties, regardless of the nature of their work or job title, whether through appointment or contracting, permanently or temporarily.
- **Establishment :** Any project managed by a natural or legal person employing one or more workers for wages of any kind.
- **Occupational Fitness :** The individual must be qualified to perform the required professional and job tasks effectively, without jeopardizing their health or the safety of others, which includes physical, mental, and psychological fitness.
- **Occupational Safety and Health :** Protecting the worker/employee from any work-related hazards that threaten their safety or health, including physical, mental, and social health.

- **Monitoring Occupational Fitness :** Identifying changes in health status due to engaging in activities and tasks that expose individuals to certain materials in the workplace, through a specialized occupational physician.
- **Occupational Medical Examination :** Surveys and clinical examinations aimed at preventing occupational diseases.
- **Occupational Physician** : is a medical doctor specializing in occupational medicine, a branch of medicine that focuses on the health and safety of workers in workplaces, aiming to prevent, diagnose, and treat occupational diseases and injuries.
- **Occupational Disease :** A disease that results from working in professions or economic activities that cause this disease, and is not attributed to external factors outside of work, provided that this disease is listed in the schedule of occupational diseases specified.
- **Profession:** A profession is a job or occupation that an individual performs regularly, requiring specialized skills and knowledge acquired through education or training, and aimed at providing a specific service or work in exchange for wages or income.
- **The Entity :** Any ministry, governmental agency, authority, public institution, fund, or their equivalents, as well as any autonomous body possessing a public legal identity.
- **High-Risk Professions and Work Environment:** Professions where workers may be exposed, either permanently or partially, depending on the duration and frequency of exposure, to high-risk activities and operations while performing their job tasks or where the ill health of an individual may compromise their ability to undertake a task defined as safety critical, thereby posing a significant risk to the health and safety of others—such as, but not limited to, construction sites, transportation services, or handling hazardous materials like chemicals or ionizing radiation—leading to an increased likelihood of occupational diseases or accidents that may result in death or severe injuries or disabilities.
- **Preventive Measures :** All precautionary measures implemented to reduce expected risks and losses.

Article Two

This regulation aims to provide a comprehensive framework for assessing the health and psychological fitness of employees/workers to ensure their ability to perform their job tasks efficiently and safely, in accordance with national standards and best international practices, which include :

1. Reducing occupational injuries, and diseases.
2. Enhancing the physical and mental fitness of employees/workers.
3. Ensuring employees/workers can perform their duties safely and effectively.
4. Defining the mechanism for pre-employmentand periodic medical examinations for those practicing high-risk professions.
5. Standardizing medical examination forms for pre-Employment, periodic, and exceptional examinations that suit each profession and providing comprehensive health databases for all employees/workers.
6. Improving compliance with local standards, regulations, and international agreements in the field of occupational safety and health.

Article Three

1. This regulation applies to all employees and workers within public sector entities, private sector companies, and non-profit organizations, in accordance with the following:
    A. New candidates pre-Employment.
    B. Employees/workers currently on duty in the following cases :
        1) After an occupational injury occurs.
        2) Upon returning from a long medical leave.
        3) When there are doubts about the worker/employee's ability to perform their job.
        4) If the job/profession requires periodic medical examinations according to the approved forms attached to this regulation.
        5) In the event of a change in the worker/employee's profession.
        6) In case of a change in the work environment.
        7) In case of using new equipment, machinery, or devices.
    C. Upon retirement from work in the case of exposure to substances with a long latency period during the employment period. Example : exposure to asbestos.
2. This regulation does not apply to medical examinations outside the scope of the job/profession.

Article Four

The first responsible person in government entities/public sector establishments and employers in the private and non-profit sectors shall be committed to the following :

1. Verification and confirmation of conducting professional fitness examinations and monitoring of employees /workers under their supervision according to the approved forms and specified professions, and making the necessary arrangements to enable the worker/employee to do so.
2. Providing the necessary resources to conduct examinations for their employees/workers.
3. Notifying the specialized occupational physician of any exposures or risks that may affect the safety and health of the worker/employee while performing their work.
4. Ensuring that the worker receives appropriate health monitoring for health and safety risks they are exposed to at work.
5. Establishing health records according to Personal Data Protection Law that containing various documents that include the occupational medical history of the worker/employee in their workplace and sharing them with the Council's secretariat through the means approved by the Council.
6. Supporting compliance with the provisions of the regulation.
7. Taking all necessary measures and precautions to organize work in accordance with the requirements of the regulation.
8. Making efforts to find alternative work if the worker's job is medically prohibited.

    A. In the event of changes in the employee's health condition or new developments in medical restrictions, the employer must reevaluate the offered alternative work and update it to accommodate the employee's health status to ensure the employee's acco in the new role while maintaining their health and safety.

    B. If the employee is unable to fully perform the alternative work duties as a result of medical restrictions, the employer is obligated to make the necessary

adjustments to the working conditions. These adjustments may include flexible working hours, part-time jobs (reduced working hours), or any other arrangement that guarantees the employee's continuing employment in a safe and suitable environment.

C. If the employee's health improves over time and they are able to return to their original job, the employer is required to undertake a comprehensive assessment to reinstate the employee to their original position in accordance with their current health condition.

Article Five

Employees and workers are committed to the following :

1. Conducting professional fitness examinations as requested by the entity or establishment, in accordance with the requirements of this regulation, using the approved forms, and based on the profession to be practiced, and responding to its requirements in coordination with the employer.
2. Disclosing symptoms, injuries, and occupational diseases, and providing any necessary health information in accordance with the approved form.
3. Informing the entity or employer or their representative of any activities or defects that could affect their safety or those around them.
4. Reporting any violations by establishments in applying the requirements of the regulation to the relevant authorities.

Article Six

The occupational fitness examination form for a worker/employee shall be selected based on the following criteria :

1. Actual work.
2. Job description.
3. Type of materials or physical, chemical, or biological factors to which the employee is exposed to.
4. Method of exposure to materials.
5. Level of exposure to materials or physical, chemical, or biological factors
6. Duration of exposure to materials or physical, chemical, or biological factors.
7. Application of preventive measures and availability of specific equipment that adheres to the occupational health and safety standards established by the Saudi Standards, Metrology, and Quality Organization regarding occupational health and safety to reduce exposure to materials according to hierarchy of control and related regulations and monitor harmful health effects.

Article Seven

Occupational fitness examinations shall not be used as à substitute for implementing effective individual and collective hierarchy of control measures except in the following cases :

1. To evaluate the effectiveness of the hierarchy of control measures for practitioners of the profession (assessing exposure levels).
2. To apply new and more effective control measures if necessary.

Article Eight

The types of medical examinations for occupational fitness include the following :

1. General medical examination :
    A. Evaluation of vital signs.
    B. Screening for chronic diseases.
2. Additional specialized investigations according to the nature of the profession and based on the approved forms.
3. Psychological evaluation to guarantee psychological and mental health and well-being.

Article Nine

The mechanism for implementing examinations shall be as follows :

1. **Pre-employmentMedical Examination :** This examination is conducted on all candidates for jobs/professions, including an analysis of medical history and history of exposure to occupational hazards, according to the approved forms based on 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 health and safety risks they are exposed to. These periodic examinations may be legally "restricted" or “statutory“ such as working in aviation, seas, food production and services, firefighting, handling weapons, and dealing with explosives and ionizing sources, among others.
3. **Exceptional Medical Examination :** Conducted in emergency cases such as post-accidents or significant changes in performance or when the specialized physician observes early signs of specific occupational diseases or having a cluster of similar cases caused by potentional exosure to toxic substances.

Article Ten

The medical examination for occupational fitness consists of three integrated programs as follows :

1. **Mandatory Occupational Fitness Examinations :** Conducted periodically and regularly according to the requirements for practicing the profession, including a mandatory occupational fitness questionnaire containing vital signs, sensory tests (mentally, hearing, vision tests), physical examinations, and tests for exposure to specific hazards including exposure to chemical substances or physical factors (such as noise, cold, heat, etc.), as well as additional dangers including the risk associated with working at heights or in tight spaces, if relevant, if any, and is considered a legally binding document.

2. **Special Occupational Fitness Examinations :** Determined based on risk assessment or working environment conditions or added by the specialized occupational physician based on other health indicators, including :
    A. Lung function tests and mask fit tests.
    B. Aerobic capacity tests.
    C. Drug tests.
    D. Other tests required by the profession (such as tests related to infectious diseases).
3. **Professional Fitness Examinations Based on Exposure or Age :** The facility must add tests based on exposure or age to the list of tests required for the profession and update this in its internal policy, in a way that does not affect the list of compulsory and special tests.
4. **Optional Examinations :** The supervising or licensed entity in the economic sector, or the primary responsible person or employer, may establish a specific policy regarding the examinations and tests that are suitable for the nature of the work within the organization, including drug test, as long as it does not conflict with this regulation or the relevant national laws, regulations, and policies.
5. **The color coding for examination levels is as follows :**

Fitness Examinations Based on Exposure or Age	Special Occupational Fitness Examinations	Mandatory Occupational Fitness Examinations

Article Eleven

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

1. Medical examination for occupational fitness for hazardous professions.
2. Statutory medical examination for occupational fitness for restricted professions.
    - The medical examinations for occupational fitness included in the occupational fitness examination forms for practitioners of high-risk professions shall be subject to the color coding for examination levels as outlined in paragraph four of Article Ten.

Article Twelve

Results of the examinations shall be handled as follows :

1. Upon completion of the pre-employmentmedical examination, the result shall be as follows :
    A. Medically fit for work and allowed to practice the profession/job they are nominated for.
    B. Medically fit for work with specified restrictions or considerations that must be adhered to when practicing the nominated profession (or when performing the profession for which the individual is selected for) including the time duration. (Addition).

C. Unfit medically for work and not allowed to practice the profession/job they are nominated for (duration should be determined).

2. If occupational fitness requirements are not met after the periodic examination, the worker/employee shall be prohibited from continuing part of or all capacities in their profession, and the supervising administration must take necessary action to adjust or change their profession unless there is sufficient evidence proving their ability to perform their job tasks efficiently and without risks to themselves or others, through additional examinations or recommendations determined by a specialized occupational medicine physician or committee of at least three specialized occupational medicine physicians. Also, the employer may exempt certain circumstances, granted that the worker's health and safety remain unaffected, with the approval of the committee and the worker.

Article Thirteen

1. The worker/employee has the right to appeal the examination results within 30 days of being notified of the examination result.
2. An independent review committee shall be formed in the Council's secretariat comprising specialists in occupational medicine and related specialties to consider appeals, with a decision to be issued within 15 days.

Article Fourteen

The medical examination for occupational fitness shall be conducted by a specialized team under the supervision of a qualified occupational consultant physician accredited by the Health Specialties Authority and licensed by the Secretariat of the National Council for Occupational Safety and Health.

Article Fifteen

The specialized occupational physician is obligated to conduct pre-Employment, periodic, and exceptional medical examinations for workers and employees according to the approved occupational fitness examination forms attached to the regulation.

Article Sixteen

1. All medical records are considered confidential documents and may only be accessed by healthcare specialists in the establishment or medical examination authorities. Workers/employees have the right to access the information contained in their health evaluation records and may request a copy, in accordance with the provisions of the Personal Data Protection Law.
2. Medical records for workers/employees or information related to health examinations may not be transferred without obtaining written or electronic consent from them.
3. Strict procedures and measures shall be adopted to ensure the security of information and technology and to protect against loss, misuse, alteration, or unauthorized access to the electronic system, in accordance with the provisions of the National Data

Governance Policy and regulations issued by the Saudi Data and Artificial Intelligence Authority.

4. The employer has the right to know the physician's decision regarding the ability to work "only," including (Fit to work, unfit to work, or Fit with restrictions or considerations with indication of any restrictions or considerations if applicable).

Article Seventeen

The regulation covers employees and workers within the Kingdom.

Article Eighteen

In the event of violations of the provisions of this regulation, the penalties and sanctions outlined in the relevant regulations and laws shall be applied.

Article Nineteen

This regulation shall be published in the Official Gazette and shall enter into force from the date of its publication, in accordance with the transitional phase management for compliance with the professional fitness system requirements included in the decision approving this regulation.

Article Twenty

The Council shall prepare a guide that includes detailed provisions and controls related to filling out forms, maintaining records and data, and approving providers and service providers (individuals/establishments), in addition to all related provisions and rules pertaining to this regulation.

الملاحق

Appndex

نماذج فحص اللياقة المهنية:

نماذج الفحص الطبي لما قبل التعيين للياقة المهنية

المرفق 1: 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 And Day Time Sleepness)	☐ 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. Any health problem, which requires visits to the doctor, or for which you take **regular drugs for**? **<u>If any of the above questions were answered</u> "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,**	☐ Yes	☐No

Industry: ---------- Job title: ---------- Employer address: ---------- Dates of employment: ---------- Type of exposure…… Duration of exposure……. Refer to Occupational Exposure questionnaire	
26. Haveyou ever received worker's disability benifits/ 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. :----------

Vaccintion 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	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:----------	

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).
- **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)
- **ARMY:**
- Hepatic and Renal function tests
- Hemoglobin electrophoresis, G6PD (Air Forces pilot and crew only)
- Spirometry
- **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 equivelent
  -
- 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 periodic medical assessments.
- 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 colour and depth perception testing
- Urine Drug Screening (pre-employmentand random)

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

FINAL DECISION OF Pre- Employment MEDICAL EXAMINATION REPORT

Pre- Employment medical examination

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 Consultant, including :**
- **FIT with considerations**
- **FIT with restrictions.**
- **UNFIT**

Name of health professional:

Signature :

Date

PRE- Employment MEDICAL EXAMINATION

المرفق 2: 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 And Day Time Sleepness)	☐ 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
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**?	☐ Yes	☐No

<u>If any of the above questions were answered</u> "yes", please give details by referencing the item number. **Provide information regarding diagnosis and treatment, including dates of treatment.**	

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 benifits/ 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

2. **If yes**, please Specify :

- Type of assessment: ----------
- Purpose : ----------
- Medical facility : ----------
- Date of examination : ----------
- Attach results if applicable. :----------

Vaccintion information :

If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA?

☐ Yes ☐No

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	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

PRE- Employment MEDICAL EXAMINATION

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:----------

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)

PRE- Employment MEDICAL EXAMINATION

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.

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

FINAL DECISION OF PRE- EMPLOYMENT MEDICAL EXAMINATION REPORT

Pre- EMPLOYMENT medical examination

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 PASSPORT **ID NUMBER:**

(Attach copy}

Medical opinion based on:

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

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

Name of Heath Professional :

Signature

Date:

PRE- Employment MEDICAL EXAMINATION

المرفق 3: 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
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

PRE- Employment MEDICAL EXAMINATION

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 And Day Time Sleepness)	☐ 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 :	☐ Yes	☐No

i. Recurring skin or ear infection ? ii. A recurring bowel disorder		
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?	☐ Yes	☐No
34. Have you ever had, or are you now known to have typhoid fever?	☐ Yes	☐No
35. Any health problem, which requires visits to the doctor, or for which you take **regular drugs**? **<u>If any of the above questions were answered</u> "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.		

PRE- Employment MEDICAL EXAMINATION

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. :----------	
Vaccintion information :	
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA? ☐ Yes ☐No	
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA	

PHYSICAL EXAMINATION

General:

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

Pulse rate: ____/min ☐ Regular ☐Irregular	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**

PRE- Employment MEDICAL EXAMINATION

(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:----------	

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
- Blood/stool CS ((a) Typhoid (b) Cholera)

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

FINAL DECISION OF PRE- EMPLOYMENT MEDICAL EXAMINATION REPORT

Pre- EMPLOYMENT medical examination

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 Consultant, including :**
- **FIT with considerations**
- **FIT with restrictions.**
- **UNFIT**

Name of health professional:

Signature:

Date:

PRE- Employment MEDICAL EXAMINATION - DIVING

المرفق 4: 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
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 And Day Time Sleepness)	☐ 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
34. Any health problem, which requires visits to the doctor, or for which you take **regular drugs**? **<u>If any of the above questions were answered</u> "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

2. **If yes**, please Specify :

- Type of assessment: ----------
- Purpose : ----------
- Medical facility : ----------
- Date of examination : ----------
- Attach results if applicable. :----------

Vaccintion 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	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**

PRE- Employment MEDICAL EXAMINATION - DIVING

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 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 ll-Xll	☐ 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)
- Aerobic capacity (minimum MET level of 12)
  - Harvard Step Test or chester treadmill walk test or Bruce protocol or equivelent
- - Waist circumference
- Spirometry
- Post-exercise PEF or FEV1
- Audiometery
- Complete blood count (if clinically indicated)
- Sickle cell test (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.

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

FINAL DECISION OF PRE- EMPLOYMENT MEDICAL EXAMINATION REPORT

Pre- EMPLOYMENT medical examination

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 Consultant, including :**
- **FIT with considerations**
- **FIT withrestrictions.**
- **UNFIT**

Name of health professional:

Signature:

Date:

PRE- Employment MEDICAL EXAMINATION - WELDER

المرفق 5: 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 And Day Time Sleepness)	☐ 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
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**? **<u>If any of the above questions were answered</u> "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,**	☐ Yes	☐No

PRE- Employment MEDICAL EXAMINATION - WELDER

Industry: ---------- Job title: ---------- Employer address: ---------- Dates of employment: ---------- Type of exposure…… Duration of exposure……. Refer to Occupational Exposure questionnaire		
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
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. :----------			
Vaccintion information :			
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA? ☐ Yes ☐No			
If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA			
PHYSICAL EXAMINATION			
General:			
Height (cm):	Weight (Kg):	BMI (consider hip: waist- to-hip ratio as best alternative)	
Pulse rate: ____/min ☐ Regular ☐Irregular	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**	

PRE- Employment MEDICAL EXAMINATION - WELDER

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 (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)
- Spirometery
- 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)

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

FINAL DECISION OF PRE- EMPLOYMENT MEDICAL EXAMINATION REPORT

Pre- EMPLOYMENT medical examination

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 Consultant, including :**
- **FIT with considerations**
- **FIT with restrictions.**
- **UNFIT**

Name of health professional:

Signature:

Date:

نماذج الفحص الطبي الدوري للياقة المهنية

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 And Day Time Sleepness)	☐ 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. Any health problem, which requires visits to the doctor, or for which you take **regular drugs**? **<u>If any of the above questions were answered</u> "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: ----------	☐ Yes	☐No

Dates of employment: ---------- Type of exposure…… Duration of exposure……. Refer to Occupational Exposure questionnaire	
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. :----------

Vaccintion information :

If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA?

☐ Yes ☐No

If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA

PHYSICAL EXAMINATION

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

Pulse rate: ____/min ☐ Regular ☐Irregular	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

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
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)
- Electrocardiogram (ECG) (above 40 years)
- Audiometry (if whisper test negative)

- HEAVY EQUIPMENT OPERATOR (every 3 years)

- **HEALTHCARE MEDICAL SHEET (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
-
- **MINING UNDERGROUND MEDICAL SHEET (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
- Respiratory FIT testing (if needed)
- **COMMERCIAL DRIVER MEDICAL SHEET (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 MEDICAL SHEET (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 equivelent
  -
- 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

Fitness Examinations Based on Age :

- **Gender and age -specific testing**
  - **For women** Mammogram, and cervical PAP smear, lower GI endoscopy
  - **For men** Lower GI endoscopy ,PSA (prostate-specific antigen) testing
  - (age limit and frequency as per public health authority specifications)

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.

FINAL DECISION OF PERIODIC 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 Consultant, including :**
- **FIT with considerations**
- **FIT with restrictions.**
- **UNFIT**

Name of Heath Professional :

Signature

Date:

PERIODIC MEDICAL EXAMINATION - DIVING

المرفق 7: 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

PERIODIC MEDICAL EXAMINATION - DIVING

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 And Day Time Sleepness)	☐ 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
34. Any health problem, which requires visits to the doctor, or for which you take **regular drugs**? **<u>If any of the above questions were answered</u> "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		

PERIODIC MEDICAL EXAMINATION - DIVING

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. :----------

Vaccintion information :

If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA?

☐ Yes ☐No

If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA

PHYSICAL EXAMINATION

General:

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

Pulse rate: ____/min ☐ Regular ☐Irregular	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 :

PERIODIC MEDICAL EXAMINATION - DIVING

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 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 ll-Xll	☐ 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 equivelent
- Exercise test
- Spirometry
- Post-exercise PEF or FEV1
- Audiometery
- 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.

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

FINAL DECISION OF PERIODIC MEDICAL EXAMINATION REPORT

Job title: **Name of the candidate:**

Job code:

ID TYPE: NATIONAL PASSPORT **ID NUMBER:**

(Attach copy}

PERIODIC MEDICAL EXAMINATION - DIVING

Fitness determination:

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

Name of health professional:

Signature:

Date:

PERIODIC MEDICAL EXAMINATION - WELDER

المرفق 8: نموذج (WELDER MEDICAL SHEET)

SEE THE APPENDIX FOR **every 3 years**
until age of 50, then every one year.

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 And Day Time Sleepness)	☐ 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
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**? **<u>If any of the above questions were answered</u> "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,**	☐ Yes	☐No

PERIODIC MEDICAL EXAMINATION - WELDER

Industry: ---------- Job title: ---------- Employer address: ---------- Dates of employment: ---------- Type of exposure…… Duration of exposure……. Refer to Occupational Exposure questionnaire		
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
If yes,		

PERIODIC MEDICAL EXAMINATION - WELDER

☐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. :----------

Vaccintion information :

If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA?

☐ Yes ☐No

If you are not fully vaccinated, are you willing to take the vaccine (s) for work purposes in KSA

PHYSICAL EXAMINATION

General:

Height (cm):	Weight (Kg):	BMI (consider hip:waist ratio)

Pulse rate: ____/min ☐ Regular ☐Irregular	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**

PERIODIC MEDICAL EXAMINATION - WELDER

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
19. Pallor	☐ Normal ☐ Abnormal
20. Edema	☐ Normal ☐ Abnormal
21. Jaundice	☐ Normal ☐ Abnormal
22. Heart (Rhythm, sounds and murmurs)	☐ Normal ☐ Abnormal
23. Cognitive functions	☐ Normal ☐ Abnormal
24. Psychiatric (appearance, behavior, mood, thoughts and communication, and memory)	☐ Normal ☐ Abnormal
25. Mouth (Tongue and tonsils), teeth and gums	☐ Normal ☐ Abnormal
26. Ears, nose, throat	☐ Normal ☐ Abnormal
27. Thyroid exam	☐ Normal ☐ Abnormal
28. Lymph node	☐ Normal ☐ Abnormal
29. Eye exam	☐ Normal ☐ Abnormal
30. Lung and Chest (not including breast exam)	☐ Normal ☐ Abnormal
31. Abdomen (including organomegaly and hernia)	☐ Normal ☐ Abnormal
32. Urinary and genital system (not including pelvic exam)	☐ Normal ☐ Abnormal
33. Upper & lower extremities (strength and range of motion)	☐ Normal ☐ Abnormal
34. Spine	☐ Normal ☐ Abnormal
35. Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Normal ☐ Abnormal
36. 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)
- Spirometery
- 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)

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

FINAL DECISION OF PERIODIC 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 Consultant, including :**
- **FIT with considerations**
- **FIT withrestrictions.**
- **UNFIT**

Name of health professional:

Signature:

Date:

END OF SERVICE MEDICAL EXAMINATION – MINING

المرفق 9: 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

END OF SERVICE MEDICAL EXAMINATION – MINING

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 And Day Time Sleepness)	☐ 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. Any health problem, which requires visits to the doctor, or for which you take **regular drugs**?	☐ Yes	☐No

END OF SERVICE MEDICAL EXAMINATION – MINING

<u>If any of the above questions were answered</u> "yes", please give details by referencing the item number. **Provide information regarding diagnosis and treatment, including dates of treatment.**	
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

END OF SERVICE MEDICAL EXAMINATION – MINING

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. :----------

Vaccintion information :

PHYSICAL EXAMINATION

General:

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

Pulse rate: ____/min ☐ Regular ☐Irregular	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**

END OF SERVICE MEDICAL EXAMINATION – MINING

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
13. Spine	☐ Normal ☐ Abnormal
14. Neurological (Equilibrium, tendon reflexes, coordination, etc,)	☐ Normal ☐ Abnormal
15. Skin	☐ Normal ☐ Abnormal

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

END OF SERVICE MEDICAL EXAMINATION – MINING

Investigation

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

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 Consultant, including :FIT with considerations or 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 my employer and 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 purposes.

Name of candidate……. Signature……

Date ……..