Medical File to be provided by any individual required to work offshore for Total E&P Angola

CONFIDENTIAL

Part 1 and 2 to be filled in by the occupational physician and the patient

Part 3, 4 and 5 to be filled in by the occupational physician

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INFORMATION TO BE READ BY THE PATIENT

The Medical Fitness Examination shall be undertaken every year. The results of this medical file should be submitted to the physician on board who will keep such information (compliance with medical secrecy). The physician or medic on board will be the depositary and no information shall be disclosed except in case of vital need of any patient (for an emergency treatment) under a status which does not allow him to express himself in full consciousness.

Refusal to inform or to answer the questions made by the medical examiner (for the establishment of the medical file) and by the onboard physician, engages the liability of the employee if any complication occurs resulting from the absence of information.

If you are taking any prescribed? Medicine, you should see a physician/medic or the vessel's master (in the absence of the medic) and inform him on such medication on board. It is strictly forbidden to give personal medications to another crew member.

Once you have filled in the medical file with the help of your occupational physician and undertaken the required examinations and once the occupational physician declares you fit to work offshore, you will only have to present your fitness to work certificate to the administrative authorities.

Any incomplete file shall prohibit you from going offshore.

Patient's signature and date

1. HEALTH INFORMATION SHEET

Medical examiner's name:

Medical specialty:

Registration number in the country's Medical Order:
Country of medical practice:
Address and Phone number:
Medical examiner's Email address:

To be filled in with the physician who is performing the fitness to work certificate
Attending physician's name:

Address:

Phone number with international prefix:

Attending physician's name:

Place and Date of medical examination:
Stamp and signature:

Patient's SURNAME:
Patient's first name:

Physical address: City: P.O box: Country:
Street:

Home phone number: Other phone numbers:

Company Information
Company name: Company phone number: City:

Position: Line manager:

Person to contact in the event of an emergency
Name: Family ties or other: Telephone number:

Personal Information
Date of Birth: Age: Sex: M/F (Social Security Number):
Height: Weight: Smoker □ Non smoker □ Yes Date of the last tetanus booster vaccination:

BMI (kg/m2) :
Referential Medical Center for medical evacuation in Angola:
Medical history (tick the appropriate boxes)
□ No health problem
□ High Blood Pressure □ Heart attack □ Cardiovascular disease
□ Diabetes
□ Glaucoma
□ Epilepsy □ **C**erebro **V**ascular **A**ccident □ Migraines
□ Fractures □ chronic inflammatory joint disease □ Muscular-skeletal problems
□ Cancer :
- type :
- date of diagnosis :

- End of treatment
□ pregnancies : yes/no
□ Asthma
□ psychiatric
□ Other :
Risk factors:

Tobacco:
- yes □ / no □
- if the answer is yes: number of packs/year:

Alcohol:
- quantity/day:

Drugs (cannabis, cocaine, etc.):

Have you ever been hospitalized □YES □ NO
If the answer is YES please explain why and when

Have you seen a doctor during the last 12 months ? □ YES □ NO
If the answer is YES please explain why and when

Surgical procedure□ YES □ NO
If the answer is YES which and when

Have you ever had any adverse reaction to anesthesia during a surgical procedure or an adverse reaction after visiting a dentist? □ YES □ NO
If the answer is YES, specify which and when

Have you ever had allergic reactions? □ YES □ NO
If yes, specify its cause:

Are you allergic to the following medications:
□ Penicillin □ Sulfonamide □ Iodine □ Morphine □ Lidocaine □Quinine
Other :

Are you taking any medicine: □ YES □ NO
If answer is yes:
International name for such medicines:
Dosage Quantities/day
Reason for taking this medicine/indication

Do you have a persistent cough for more than a week? □ YES □ NO

Have you had unexplained night sweats? □ YES □ NO

Have you had a sudden weight loss for any reason? □ YES □ NO

Have you made any blood donation during the last 12 months ? □ YES □ NO

Your blood type: ……

Please fill in the questionnaire on the exposure to work related risks and submit it to your doctor (Cf Appendix)

Date and signature of the patient confirming the validity of information provided to the medical examiner.

Any false statement or voluntary omission leading to medical complications engages the liability of the signatory

2. QUESTIONNAIRE ON THE EXPOSURE TO HAZARDS

	To be delivered to the physician who is performing the offshore medical examination				
	POSITION IN THE COMPANY	NAME OF EMPLOYEE **Please tick all daily exposures to which your are subject when offshore, performing your work activity**			
	Physical hazards	**Potential risks**	**Prevention means**	**Monitoring, examinations to be performed**	**Frequency of examinations**
	Working in noisy areas higher than 85 dB (A)	*Threshold shift, hearing loss*	*Double Hearing Protection*	Audiogram at hiring	Annual
	Working with vibrating hand-held machines	Hand-arm vibrating syndrome, carpal tunnel syndrome	*Reduction of working hours, replacement of tools*	Clinical examination	Annual
	Welding	*Toxic fumes, non ionizing radiation*	*Specific PPE, local ventilation by aspiration*	NFS/an	RP/annual EFR/annual
	Work in a confined space	*toxic gases, significant physical effort*	*ARI if necessary, work permit, monitoring*	Clinical examination NFS EFR	Annual Annual
	Work at height	*fall, important physical effort*	*work permit, fall protection*	balance clinical examination (vestibule, ear, eyes) ECG	Annual
	Traveling by air plane	*Deep-vein thrombosis*	*Exercising, hydration support stockings if flight > 6 h*	Clinical examination	Annual
	Traveling by helicopter	*Noise, vibrations, deep vein thrombosis*	*Hearing Protection, HUET, safety briefing before boarding*	Clinical examination	Annual
	Traveling in a fast crew boat	*vibrations, falls*	*wearing EPI, stand at the rail, follow crew's instructions*	Clinical examination	Annual
	Subsea diving	*Decompression accidents, ENT pathologies, etc.*	*Risk training*	Fitness Certificate issued by a Hyperbaric certified physician	6 months or according to center's recommendation
	Manipulation of chemical substances	*Exposure to toxic carcinogenic*	*VLEP,PPE, local ventilation through aspiration*	Clinical examination NFS	Annual
	Handling and Lifting	*Muscular skeletal Disorders*	*Mechanical Lifting Devices, training*	Clinical examination	Annual,
	Office work/on screen	*Visual Fatigue*	*Ergonomics training, wearing suitable corrections*	Visual clinical examination	Annual
	Work in a hot environment	*Dehydration, hyperthermia*	*Frequent breaks and re-hydration*	Clinical examination	Annual
	Manipulation of foodstuffs	*Diseases related to the ingestion of water and contaminated food, "manual handling"*	*Specifications on restaurant and frequent audits, Hand washing*	Clinical examination KOP/copro	Six-monthly
	Medical acts, First aid, contact with bio-waste	*Contact with pathogens, biological hazards*	*PPE, mask, gloves, glasses, vaccinations*	Clinical examination Hepatitis B serology Vaccination Checks	Annual
	Other				

3. CLINICAL EXAMINATION

The patient must be free from any Neurological, Psychic, cardiovascular, respiratory, Abdominal, Nephro-urological, ENT, joint, skin, dental symptoms (**teeth and gums must be healthy or treated**). In case of visible symptoms, please specify.

After the clinical examination, in case of emergency evacuation offshore, the patient should be able to take stairs or a ladder with a height of 30m without pause. If uncertain, the doctor may request additional tests.

4. PARACLINICAL EXAMINATIONS

A. Annual Blood Test (ATTACH A PHOTOCOPY)
NB: HIV serological tests are mandatory for staff working in Angola

Leukocytes		AST			VHA Ac (only during initial visit)		HBsAg	
Granulocytes		ALT		creatinine			AcHBs	
eosinophils		GGT			HCV Serology			
Lymphocytes							LDL	
RBC's				Fasting Blood Glucose	HIV1		HDL	
Hemoglobin					HIV2		Triglycerides	
MCV								
Platelets								

B. **Fasting Urinalysis** : Annual Urinary Dipstick

Leukocytes		blood	
nitrites		protein	
glucose			
ketones			

C. **Parasitological examination of stool** every year including those handling food

D. **immunological testing of stool for colon cancer** (if not possible make a HEMOFEC)

Results

E. **Vaccinations and dates**

Results:

F. **Audiometry / annual (repeat if any symptoms)**

Results: (provide the audiogram, the patient should be able to present it on board)

G. Intradermal reaction to the tuberculin toxin only for hiring

Results:

H. Chest X-ray / annual (repeat in the event of symptoms)

Results: (provide a report from the radiologist)

I. Resting ECG / year (ATTACH A PHOTOCOPY)

Results: (provide a 12 lead ECG, the patient should be able to present it on board)

J. Risk-based cardiological notice on the advice of OFFSHORE physician :

Results: (the patient should be able to present cardiological report when on-board)

Fitness for Work Medical Certificate

The undersigned, Dr. ……..

certifies having examined ……,

employed at the company ……, born on ……./……./…….....

and with Identification number ……, with position of ……

Exam type:

☐ Initial ☐ Periodic ☐ Occasional

Is:

☐ Fit ☐ Unfit

To perform the job OFFSHORE in ANGOLA, for which the risks have been described in the medical file attached hereto.

The file must be sent in a sealed envelope to the medical support OFFSHORE via the patient and in a CONFIDENTIAL way. Only the Fitness Sheet may be submitted to the administrative authorities.
When the patient is to leave the offshore premises, he/she shall recover his/her medical file with the Medical Support.

Date: Expiration date:

Examining doctor: Patient:

Medical license number:

Doctors email: Patient signature:

Mandatory Signature and Stamp: