

<<Name / Surname / Date of birth:>>

MEDTRACK PERIODICAL HEALTH CHECK FORM FOR SHELF DRILLING

A. CONSENT TO HEALTH CHECK, INCLUDING HEALTH MONITORING, VACCINATION, RECORD RETENTION AND RELEASE OF MEDICAL INFORMATION

I understand that Shelf Drilling ("my employer/prospective employer") has engaged International SOS Assistance (Proprietary) Limited (the "Co-ordinator") to provide any or all of the following logistic services (the "Logistic Services") as may be directed by my employer/prospective employer:

Co-ordination and medical review of Health Check examinations: Pre-Employment; National Travelling Frequently; Return to Work; Regional/Seconded Initial; Transfer; Dependent Medical; Special Assessment

I understand that my employer/prospective employer has engaged the Co-ordinator to coordinate with independent Medical Service Providers (defined below) for whom the Co-ordinator does not have any responsibility or liability to provide the following services (the "Health Check") directly to me:

- i. Medical Examination
- ii. Diagnostic testing
- iii. Vaccination
- iv. Other services directly provided by the Medical Service Providers (defined below)

I hereby consent to undergo the Health Check.

I acknowledge and agree that the Health Check I am about to undergo will provide information to the Co-ordinator's MedTrack Department in Johannesburg, South Africa to evaluate my state of health.

B. CONSENT FOR BLOOD TESTING

I hereby consent to undergo Hepatitis B, Hepatitis C, Syphilis and Human Immune Deficiency Virus (HIV) test (as and when required for health check purposes), which will be conducted by a Medical Service Provider (defined below) and who will provide the test results directly to the coordinator and a designated medical practitioner of the Client (where applicable).

I hereby agree that this is a medical screening assessment for consideration by the Client for relocation purposes only. Whilst medical conditions need to be addressed, any treatment or discussions related to the management of them will need to be consulted in a separate appointment with the Medical Services Providers or your treating physician.

C. ACKNOWLEDGEMENT AND AGREEMENT

I hereby acknowledge, understand and agree:

- (i) That the Co-ordinator will assist to make referrals for me to undergo the Health Check and blood testing conducted by independent third-party medical providers or laboratories (the "Medical Service Providers"). In making such referral:
 - a. The Co-ordinator and my employer/prospective employer will not be responsible for the Health Checks and/or blood testing nor be liable for any consequences arising out of or caused by the services provided by the Medical Service Providers, including but not limited to, the chain of custody procedures, diagnostic processes, accuracy and interpretation of results provided by the Medical Service Providers; and
 - b. None of the Co-ordinator, my employer/prospective employer or the Medical Service Providers assumes any responsibility to diagnose any medical condition I may have or to treat me, or to undertake responsibility for my ongoing care.
- (ii) That the Medical Service Providers are hereby authorised to release the results of the Health Check to the Co-ordinator, my employer/prospective employer and/or its related companies, including International SOS group companies, and their respective officers, employees, representatives, agents and contractors.
- (iii) That the Health Checks I will undergo will simply allow the Medical Service Providers and the Co-ordinator to evaluate my state of health and provide a fitness for work recommendation based upon guidelines provided by my employer/ prospective employer. The Co-ordinator does not control the requirement to undergo the Health Checks and has a limited role in making recommendation on fitness based on my employer/prospective employer's health guidelines. I further acknowledge that any employment-related decisions in connection with the Health Checks are the sole responsibility of my employer/ prospective employer and I agree that the Co-ordinator is not responsible for the final outcome as may be decided by my employer/prospective employer.
- (iv) To the collection, processing, use, recording and/or storage of the information provided or arising pursuant to the Health Check, including sensitive personal data, by or on behalf of the Co-ordinator. To this extent, I hereby further authorize the Co-ordinator to:

<<Name / Surname / Date of birth:>>

- a. Maintain my Health Check results together with my medical history;
 - b. Release my examination and health records to a designated medical practitioner of my employer/prospective employer in a confidential manner;
 - c. Provide a summary of fitness recommendations to a designated authorized person of my employer/prospective employer and
 - d. Provide to medical personnel and related companies of the Co-ordinator, including International SOS group companies, involved in my care access to a summary of health check results in situations where I need medical attention.
- (v) To hold harmless my employer/prospective employer, the Co-ordinator, their respective related companies, including International SOS group companies, and their respective officers, employees, representatives, agents and contractors, from any liability whatsoever arising or in connection in whole or part from the Health Check and blood testing and use by my employer/prospective employer or otherwise of results from the Health Check and/or blood testing. In the event that the Co-ordinator, my employer/prospective employer and/or any of their respective related companies, including International SOS group companies, are required by applicable law or statutory or governmental rules and regulations, including future changes or changes in the interpretation of the same, to preserve, disclose or release any or all the results of such tests, I will not hold the Co-ordinator, my employer/prospective employer and/or any of their respective related companies, including International SOS group companies, liable in any way for such preservation, disclosure or release of information.
- (vi) I consent to the collection, processing, use, recording and/or storage of my personal data, including sensitive personal data described above and to the transfer of such data outside the country where my medical examination is performed to third countries that do not have or may not have the same level of protection as the one in the country where my medical examination is performed.
- (vii) That I have the option of consulting or rectifying my medical file kept by or on behalf of the Co-ordinator upon request to do so in writing to the authorized Doctor of the Co-ordinator Health Check Department.
- (viii) I agree to have online my personal data, including sensitive data, (or part of it) on a secure website operated by or on behalf of International SOS accessible to myself, the Co-ordinator and the authorized person of my employer/prospective employer.

I understand a copy of the Coordinator's privacy policy statement, including information about access, may be obtained by writing to: Director of Assistance, International SOS Assistance (Proprietary) Limited or from the International SOS website.

I further understand that I have a right to receive copies of my personal information upon request. I understand that I have the right to refuse to sign this consent form, and that if I do refuse, the Co-ordinator may be prevented from or limited in providing the services described above. By signing this consent form, I authorize the use or disclosure of my protected health information as described above.

I agree that a copy, including Photostat, electronic or fax copy of this signed form shall be considered as effective and valid as the original and specifically authorize its use as such. I have the right to receive a copy of this form after I have signed it.

I acknowledge that my employer/prospective employer, the Coordinator, their respective related companies, including International SOS group companies and/or their respective representatives and/or agent, will rely upon the truthfulness of the particulars supplied by me in respect of the Health Check and blood testing.

This signed form is valid until a revocation signed by me is received by the Co-ordinator. I acknowledge that if I sign this form, I will have the right to revoke it at any time, except to the extent that the Co-ordinator and any permitted recipient of my personal information have already taken action based on my consent and/or authorization. To revoke this consent and/or authorization, I must write to the Co-ordinator at the address, fax and/or e-mail address set out below.

By signing this consent form, I confirm that I have read and fully understood the above terms and conditions and that all of my questions about this form have been satisfactorily answered. I also declare that statements made on this form are accurate and all known medical history has been stated. I acknowledge that the Co-ordinator and my employer/prospective employer will rely upon the accuracy and completeness of all statements made by me.

Consent given on (date): _____

By (Print Name): _____

Signature: _____

(Initial previous page please)

Please send this form duly signed to:

MedTrack Department International SOS Johannesburg

Attention: MedTrack Department Johannesburg

Address: P O Box 4561, Halfway House

South Africa, 1685

Fax: +27 86 528 2982 or +27 86 528 2674

E-mail: shelfmedtrack@internationalsos.com

<<Name / Surname / Date of birth:>>

MEDTRACK (PERIODICAL) MEDICAL EXAMINATION FORM

TO BE COMPLETED BY THE EMPLOYEE

Employee's Last Name	_____	First Name	_____
Dependent's Last Name	_____	First Name	_____
Sex	_____	Birth Date	_____
			mm/dd/yy
Home Phone	_____	Nationality	_____
Home Address	_____ _____		
Email Address**	_____ _____		

CLEARLY INDICATE YOUR COMPANY INFORMATION:

PLEASE CHECK YOU HAVE ANSWERED ALL THE QUESTIONS ON THE ABOVE PAGE

I hereby authorize the release of this medical information to International SOS Assistance (Pty) Ltd. I also authorize International SOS Assistance (Pty) Ltd. and its affiliates to receive, deliver and/or disclose information concerning my medical history to medical professionals, including Shelf Drilling Director of Medical Services, in the coordination of my health care needs.

Date mm/dd/yy

Signature

For further information on the privacy and security of your medical information please see the International SOS Notice of Privacy Practices, available upon request or at <http://www.internationalsos.com/privacy.cfm>.

*This form is not intended for dependents under 16 years of age. Refer to provider guidelines for additional information.

** Email address is used only for administrative correspondence. No personal medical information will be sent via email. If you do not have a personal email address at this time, please use your rig email address in the interim.

<<Name / Surname / Date of birth:>>

MEDTRACK HEALTH CHECK FORM FOR SHELF DRILLING PERIODICAL

QUESTIONNAIRE TO BE COMPLETED BY THE EMPLOYEE:

First and Last Name						
Address						
Home Phone 1		Home Ph 2		Mobile		
If Employee, indicate Job/Position. If Adult dependant, tick the box	<input type="checkbox"/> Employee's Job/Position: <input type="checkbox"/> Adult dependant					
Date of Birth		Email				
Select the anticipated most frequent tasks to be performed	<input type="checkbox"/> Sit <input type="checkbox"/> Stand <input type="checkbox"/> Walk <input type="checkbox"/> Drive <input type="checkbox"/> Push/Pull <input type="checkbox"/> Reach <input type="checkbox"/> Squat <input type="checkbox"/> Kneel					
	<input type="checkbox"/> Climb stairs <input type="checkbox"/> Climb ladders <input type="checkbox"/> Lift/carry weight <input type="checkbox"/> Use of hand/fingers <input type="checkbox"/> Reach of work above shoulder					
Overseas assignment involved	<input type="checkbox"/> Yes <input type="checkbox"/> No	Off-shore assignment involved		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Future location (if known) (City, Town or Project Name):			Country (if known):			
Date of Departure (dd/mm/yyyy)			Date of Return (dd/mm/yyyy)			

EXAMINING MEDICAL OFFICER (DOCTOR) OR NURSE

PLEASE COMPLETE THE HEALTH HISTORY SECTION BELOW (WHEN POSSIBLE)

A. MEDICAL HISTORY

Has the applicant ever had or is suffering from any of the following conditions?

1. EAR, NOSE, THROAT, EYES							
		YES	NO			YES	NO
a.	Fainting spell	<input type="checkbox"/>	<input type="checkbox"/>	g.	Defective hearing	<input type="checkbox"/>	<input type="checkbox"/>
b.	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	h.	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
c.	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	i.	Obstructive Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
d.	Frequent colds, repeated sore throats	<input type="checkbox"/>	<input type="checkbox"/>	j.	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
e.	Frequent nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	k.	Eye trouble or injury (Including Colour vision problems)	<input type="checkbox"/>	<input type="checkbox"/>
f.	Discharging ears	<input type="checkbox"/>	<input type="checkbox"/>	L.	Defective Vision	<input type="checkbox"/>	<input type="checkbox"/>

<<Name / Surname / Date of birth:>>

2. CARDIO VASCULAR

		YES	NO			YES	NO
a.	Heart problem	<input type="checkbox"/>	<input type="checkbox"/>	f.	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
b.	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	g.	Swelling of ankles or feet	<input type="checkbox"/>	<input type="checkbox"/>
c.	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	h.	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
d.	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	i.	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
e.	Numbness or tingling of chest/arms	<input type="checkbox"/>	<input type="checkbox"/>				

3. RESPIRATORY SYSTEM

		YES	NO			YES	NO
a.	Pneumonia, pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	c 3.	- Blood-streaked sputum	<input type="checkbox"/>	<input type="checkbox"/>
b.	Asthma, hay fever	<input type="checkbox"/>	<input type="checkbox"/>	c 4.	- Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
c.	Following symptoms lasting 3-4 weeks or longer (isolated or in association)			c 5.	- Fever / Fatigue / Tiredness	<input type="checkbox"/>	<input type="checkbox"/>
c 1.	- Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	c 6.	- Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
c 2.	- Production of sputum	<input type="checkbox"/>	<input type="checkbox"/>	c 7.	- Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>

4. GASTRO INTESTINAL URINARY SYSTEM

		YES	NO			YES	NO
a.	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	f.	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
b.	Stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>	g.	Chronic diarrhoea, constipation	<input type="checkbox"/>	<input type="checkbox"/>
c.	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	h.	Kidney or bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
d.	Indigestion, heartburn	<input type="checkbox"/>	<input type="checkbox"/>	i.	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
e.	Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>				

5. JOINTS – MUSCLES

		YES	NO			YES	NO
a.	Arthritis, rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	e.	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
b.	Pain in articulation joints	<input type="checkbox"/>	<input type="checkbox"/>	f.	Trick or locked knee	<input type="checkbox"/>	<input type="checkbox"/>
c.	Backaches, sciatica, lumbago	<input type="checkbox"/>	<input type="checkbox"/>	g.	Flat feet	<input type="checkbox"/>	<input type="checkbox"/>
d.	Back injury	<input type="checkbox"/>	<input type="checkbox"/>	h.	Muscles, sprain	<input type="checkbox"/>	<input type="checkbox"/>

<<Name / Surname / Date of birth:>>

6. MISCELLANEOUS

		YES	NO			YES	NO
a.	Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	i.	Sought counseling or care for mental health in the past year	<input type="checkbox"/>	<input type="checkbox"/>
b.	Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>	j.	Presently taking medication	<input type="checkbox"/>	<input type="checkbox"/>
c.	Dermatitis (or skin rash)	<input type="checkbox"/>	<input type="checkbox"/>	k.	Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
d.	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	l.	Advised to have surgery	<input type="checkbox"/>	<input type="checkbox"/>
e.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	m.	Menstrual disorders (females only)	<input type="checkbox"/>	<input type="checkbox"/>
f.	Received any worker's compensation	<input type="checkbox"/>	<input type="checkbox"/>	n.	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
g.	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	o.	Cigarettes per day (list how many)	_____	
h.	Alcohol grams per week (10 g = 1 can beer = 1 glass wine = 1 glass / nip spirit)					_____	

7. For any "yes" answered items (between 1 – 6) above please explain:

Empty space for explanation of "yes" answers.

8. Any other Chronic Medical Conditions not listed above:

Empty space for other chronic medical conditions.

9. Current list of Medication Taken:

Empty space for current list of medication taken.

<<Name / Surname / Date of birth:>>

K-S. INVESTIGATIONS

Please submit the results of any tests as attachment if not captured in this form.

(Please note: that if the member has brought results with them that are less than six months old and the doctor is happy on review of these results to utilize them, then these tests would not need to be repeated.)

K. BLOOD GROUP

Test if not already known

L. BLOOD ANALYSIS (Do not transcript values on the form if laboratories results are attached)

L3. Extended

Differential Count-Neutrophils	_____ %	Aspartate Transaminase	_____ U/L			
Differential Count-Eosinophils	_____ %	Alanine Transaminase	_____ U/L			
Differential Count-Basophils	_____ %	Gamma Glutamyl Transferase	_____ U/L			
Differential Count-Lymphocytes	_____ %	Cholesterol-Total	_____ mmol/L			
Differential Count-Monocytes	_____ %	High Density Lipoprotein Cholesterol	_____ mmol/L			
Red Blood Cell	_____ M/mm3	Low Density Lipoprotein Cholesterol	_____ mmol/L			
White Blood Cell Count	_____ /mm3	Triglyceride	_____ mmol/L			
Haemoglobin	_____ g/dl	Uric acid	_____ mmol/L			
Hematocrit	_____ %	Creatinine	_____ mmol/L			
Platelets	_____ 10 ⁹ /L	Fasting Blood Glucose	_____ mmol/L			
Erythrocyte Sedimentation Rate - ESR	_____ mm/h	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; height: 20px;"> </td> <td style="width: 15%; text-align: center;">Pos</td> <td style="width: 15%; text-align: center;">Neg</td> </tr> </table>			Pos	Neg
	Pos			Neg		
HbA1c	_____ mmol/L					
PROSTATE SPECIFIC ANTIGEN (males 45 years and older)		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; height: 20px;"> </td> <td style="width: 15%; text-align: center;">Pos</td> <td style="width: 15%; text-align: center;">Neg</td> </tr> </table>			Pos	Neg
	Pos	Neg				

M. CARDIAC

M.1 RESTING ECG

Normal	Abnormal	Details

M.2 STRESS ECG – BRUCE PROTOCOL (above 50 years of age or if clinically indicated)

Normal	Abnormal	Details

N. RADIOLOGICAL INVESTIGATIONS

N1. CHEST X RAY (AP)

Normal	Abnormal	Details

<<Name / Surname / Date of birth:>>

N2. LUMBAR X RAY

Normal	Abnormal	Details

N3. MAMMOGRAPHY (if indicated)

Normal	Abnormal	Details

O. RESPIRATORY FUNCTION

	Normal	Abnormal	Details
Spirometry General			

P. AUDIOMETRY

Values dB(A)

	Normal	Abnormal	Low (0.5,1,2 kHz)	High (3,4,6,8 kHz)
Right Ear				
Left Ear				

Q. URINE ANALYSIS

Albumin		Sugar		Blood	
---------	--	-------	--	-------	--

R. STOOL ANALYSIS

Blood :	Pos <input type="checkbox"/>	Neg <input type="checkbox"/>
Parasites:	Pos <input type="checkbox"/>	Neg <input type="checkbox"/>

S. PAP SMEAR (if indicated)

Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Comments:	
---------------------------------	-----------------------------------	-----------	--

<<Name / Surname / Date of birth:>>

T-V. VACCINATIONS UPDATE

T. Please provide or update a vaccination booklet. If applicable, you may download the WHO vaccination booklet from the following source: http://www.who.int/ihr/ports_airports/icvp_note/en/index.html.

Please ensure that you stringently risk assess the country-specific travel health requirements and that you offer the appropriate vaccinations and anti-malarial medication.

- **W. RECOMMENDED** vaccinations offered and updated must be assessed against country(ies) of assignment specifically. For further information on country-specific recommended vaccinations, please refer to the following source: <http://wwwnc.cdc.gov/travel/destinations/list.htm>.

Indicate **ONLY** vaccinations offered **AND** performed during this examination

Hepatitis A Hepatitis B Polio Meningitis (A&C) Typhoid Diphtheria Tetanus

Others: _____

- **V. REQUIRED** vaccinations only refer to Yellow Fever. Please ensure that the Yellow Fever vaccination is up to date based on country(ies) of transit and assignment. For further information, please refer to the following source: <http://www.cdc.gov/yellowfever/>.

Yellow Fever

W. MALARIA PROPHYLAXIS:

As a reminder:

- **If pregnancy is ongoing or expected during the coming assignment to a malaria endemic area, please inform about the risk that malaria could pose to the patient and her fetus.**
- **If pregnancy is declared and/or suspected, please refer the case to Intl.SOS medical team under this program.**
- **Procure a medication supply sufficient for a period of 3 months. Instruct the patient to contact a medical provider afterwards.**

Indicate for medico-legal reason the following **IF APPROPRIATE**:

General information on preventive action to avoid mosquito bites, and how to recognize early symptoms of malaria and how to proceed in suspected case have been given to candidate(s): Yes No

<<Name / Surname / Date of birth:>>

X. FUNCTIONAL CAPACITY TEST:

Questionnaire & Indicators

To be completed by the examining physician using the employee's interview, his clinical findings and possibly simple tests as highlighted below. Please refer to the Medtrack Approved Provider Guidelines for further instruction.

NB. Functional Capacity Checklist should only be performed in members physically capable of doing so and with the member's consent. If the member exhibits any signs of exhaustion, discomfort or pain, please terminate the testing and document accordingly.

Occupational History	• Number of years in a physically demanding position	0	Below 15 yrs	1	Above 15 yrs
	• Known pre-existing musculoskeletal condition	0	No	2	Yes
	• Relapse over past 12 months (if applicable)	0	No	2	Yes
	• Above facts correlated by imaging findings (X-Ray, MRI)	0	No	1	Yes
	• Recent surgical procedure carrying a potential functional impact.	0	No	1	Yes
	• Anti-inflammatory, analgesic and/or equivalent medications being taken?	0	No	2	Yes
	• Current musculoskeletal condition	0		2	
Aerobic Capacity	• Chester test (or equivalent, or a Stress Test that could have been done as part of the checkup).	0	Average	1	Below Average
PEFR	• PEFR (Peak-Flow or Spirometry)	0	Average	1	Below Average
Neuromusculoskeletal Evaluation	• Neuromusculoskeletal examination	0	Normal	1	Abnormal
	• Balance & coordination	0	Normal	1	Abnormal
Body Mass Index	• BMI	0	Below 40	1	Above 40
Biomechanical indicators	• Sit & Reach test (or equivalent)	0	Average	1	Below Average
	• Squat test (or equivalent)	0	Average	1	Below Average
Total Scoring					

<<Name / Surname / Date of birth:>>

REFERRAL INDICATED

- | | | |
|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Family Problems | <input type="checkbox"/> Neurologic |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> GI | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Dental | <input type="checkbox"/> GU | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Dermatologic | <input type="checkbox"/> GYN | <input type="checkbox"/> Pulmonary |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Eye | | |

PROVISIONAL MEDICAL DISPOSITION

- FINAL DETERMINATION MADE BY SHELF DRILLING HEALTH ADVISOR(S) -

- No Restriction:** The review of the medical examination results and the examining physician's recommendations against the occupational health risk assessment criteria indicates that no medical condition has been highlighted and/or confirmed which could prevent the individual's deployment.
-
- Level 1:** The review of the medical examination results and examining physician's recommendations against the occupational health risk assessment criteria indicates there is some evidence of a potential medical condition that requires further attention and follow-up. The medical findings do not prevent the individual from performing his/her normal duties, but due to the nature of the assignment which includes international travel and/or offshore visits/ assignment, it is essential to proceed rapidly and get the necessary follow up completed and documented back to International SOS medical Team within 60 days
-
- Level 2:** The review of the medical examination results and the examining physician's recommendations against the occupational health risk assessment criteria indicates there is high evidence of a (potential) medical condition that requires urgent attention and follow-up. The individual is requested to contact the International SOS medical team as soon as possible to discuss the findings and define the most appropriate course of action before he/she travels internationally and/or resumes an offshore assignment.

Comments (If any restriction is identified, or if temporary unfit and/or not assignable, please explain):

Medical provider's signature and stamp

I certify that the above review process has been completed.

Date (dd/mm/yyyy)

End of Health Review

Please fax all results to:	Or Please email all original results to:	All enquiries should be directed to: (Please do not post medical results to this address, only fax or e-mail results and maintain the original)*
Medtrack Department International SOS Assistance (Proprietary) Limited Fax: +27 86 528 2982 or +27 86 528 2674	Medtrack Department International SOS Assistance (Proprietary) Limited shelfmedtrack@internationalsos.com	International SOS MedFit Department P. O. Box 4561 Halfway House South Africa, 1685 Tel: + 27 11 541 1378

Administrative office hours: Monday to Friday 06h00 – 18h00, GMT +2

Medical office hours: Monday to Friday 08h00 – 17h00, GMT +2

***Please send invoices to the address provided on the Guarantee of Payment**