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|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------|-----------------|
|  | <b>HSEC Management System</b>                                                | Doc. No.       | HSEC FOR 031023 |
|                                                                                   |                                                                              | Version:       | 1.0             |
|  | <b>Simandou project</b><br><b>Medical Assessment_Long stay_International</b> | Reviser:       | Sofiane Chebli  |
|                                                                                   |                                                                              | Approved by:   | John Perry      |
|                                                                                   |                                                                              | Approval date: | 21/11/2023      |

**PRIVACY NOTICE:**

Simfer SA is a member of the Rio Tinto Group and is committed to protecting the health and safety of our workforce. Medical assessment and approval is required prior to travelling to Guinea for the Simandou Project

The medical assessment must be conducted at an approved Clinic and results submitted to the Simfer Medical Team at [simfermedicalteam@riotinto.com](mailto:simfermedicalteam@riotinto.com) for review and approval.

The personal data requested on this form (**your personal data**) includes detailed health information about you and is required for the purposes of:

- determining if you are fit for travel to Guinea and work on Simandou project.
- providing you with appropriate medical care if needed whilst you are in Guinea.
- ensuring you have all the mandatory vaccinations.
- ensuring you have been advised and offered the highly recommended vaccinations.
- ensuring you have been advised that malaria chemoprophylaxis is highly recommended.

The purpose of requiring this information is because working in Guinea poses significant health risks. This includes limited access to medical facilities and services, exposure to a range of vector borne and infectious diseases, and delays in medical evacuation should it be required. These factors may impact your health and especially if you have a pre-existing medical condition.

Your personal data will be processed by the Simfer Medical Team for the Simandou Project. If there are medical abnormalities noticed on your assessment form, the Simfer Medical Team may share your personal data with an external doctor engaged to provide services to Rio Tinto. Your personal data will not be shared with anyone else unless you require urgent medical treatment and/or need to be evacuated because you have a serious medical problem. In such circumstances your personal data may need to be shared with the Rio Tinto Health team or other health professionals providing services to Rio Tinto such as International SOS, or your insurance provider (on a strictly 'need to know' basis).

Rio Tinto relies on its legitimate interests to process this personal data relating to you, and specifically its interest in ensuring workplace health and safety. If you are a Rio Tinto employee based in a country where your consent is needed in order to collect your personal data or your health information or both, Rio Tinto relies on your consent to do so. Your personal data will be retained for the period that you are assigned to the Simandou project, after which time it will be archived for a two-year period and then securely deleted.

Under the Rio Tinto [Data Privacy Standard](https://www.riotinto.com/sustainability/policies) (available from <https://www.riotinto.com/sustainability/policies>) you have data privacy rights, including the right to seek access to or rectification of records containing your personal data and to be provided with information data processing. To exercise data subject rights described in the Data Privacy Standard, please contact [Simfermedicalteam@riotinto.com](mailto:Simfermedicalteam@riotinto.com) or email [askE&C@riotinto.com](mailto:askE&C@riotinto.com).

**Acknowledgement and Consent:** I confirm that I have read this Privacy Notice and that I agree to the processing of my personal data (including my health information) as described above. I also understand that processing of my personal data (including my health information) may be undertaken where necessary to comply with Rio Tinto's legal obligations and that where processing of my personal data (including my health information) is based on my consent, I can withdraw that consent by notifying [Simfermedicalteam@riotinto.com](mailto:Simfermedicalteam@riotinto.com)

|                     |                                                                                                |                  |
|---------------------|------------------------------------------------------------------------------------------------|------------------|
| Print Name: LI PENG | Signature:  | Date: 10/06/2024 |
|---------------------|------------------------------------------------------------------------------------------------|------------------|



|                                                                                   |                                                                                                                                       |                |                 |
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|  | <h2 style="text-align: center;">HSEC Management System</h2>                                                                           | Doc. No.       | HSEC FOR 031023 |
|                                                                                   |                                                                                                                                       | Version:       | 1.0             |
|  | <h3 style="text-align: center;">Simandou project</h3> <h3 style="text-align: center;">Medical Assessment_Long stay_International</h3> | Reviser:       | Sofiane Chebli  |
|                                                                                   |                                                                                                                                       | Approved by:   | John Perry      |
|                                                                                   |                                                                                                                                       | Approval date: | 21/11/2023      |

### CONFIDENTIAL

The completed Form is to be emailed to the Simfer Medical Team: [Simfermedicalteam@riotinto.com](mailto:Simfermedicalteam@riotinto.com)

#### 1- PERSONAL INFORMATION: to be completed by the Applicant.

|                       |           |              |               |            |
|-----------------------|-----------|--------------|---------------|------------|
| First and Last Name   | LI PENG   |              | Date of Birth | 07/09/1986 |
| Nationality           | CHINESE   |              |               |            |
| Employer              | RIO TINTO |              |               |            |
| Indicate Job/Position | ADVISOR   |              |               |            |
| Purpose of the travel | TRAVAIL   |              |               |            |
| Home address          | CANGA     |              |               |            |
| Home Phone            | 627496526 | Mobile Phone | 612004980     |            |
| Passport /ID Number   | PE2306946 | Expiry Date  | 14/06/2028    |            |
| Email                 |           |              |               |            |
| Emergency Contact     | Name      | RIO TINTO    |               |            |
|                       | Phones    | 622874171    |               |            |
|                       | Email     |              |               |            |

#### 2- HEALTH QUESTIONNAIRE: To be completed by the Applicant

Complete all questions truthfully. If answered "YES" – please provide further details in the comments section.

**Have you ever had or are you currently suffering from any of the following conditions?**

| 1.                                             | Family History (Parents)                                     | YES                      | NO                                  |
|------------------------------------------------|--------------------------------------------------------------|--------------------------|-------------------------------------|
|                                                | Heart Disease or High Blood Pressure                         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|                                                | Epilepsy or Convulsions                                      | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|                                                | Glaucoma or Blindness                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|                                                | Diabetes Mellitus (sugar sickness)                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|                                                | Cancer / Blood Disease                                       | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|                                                | Hereditary Disease / Congenital Abnormalities                | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|                                                | Respiratory Diseases (Pneumonia, Pneumoconiosis, TB, Asthma) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Provide further comment for items marked "YES" |                                                              |                          |                                     |
|                                                |                                                              |                          |                                     |
| 2.                                             | Medical History                                              | YES                      | NO                                  |
| 2.1                                            | Central Nervous System                                       |                          |                                     |



|                                                                                                                                                                     |                                                             |                |                 |
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|                                                                                                                                                                     |                                                             | Approval date: | 21/11/2023      |



### Simandou project

## Medical Assessment\_Long stay\_International

|                                                                                                                              |                          |                                     |
|------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|
| Frequent or Severe Headaches / Migraine                                                                                      | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Dizziness, blackouts, or Unsteadiness                                                                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Head Injury / Concussion / Unconsciousness                                                                                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Epilepsy or fits if any kind                                                                                                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Any Mental / Psychological Disorder / Phobia                                                                                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <b>2.2 Cardiovascular System</b>                                                                                             |                          |                                     |
| Heart Disorders e.g., Rheumatic fever, heart murmur, shortness of breath, palpitations, chest pains, angina, or heart attack | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| High blood pressure, high cholesterol or circulatory disorder including a stroke, cramps in the calves with exercise         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <b>2.3 Lower Respiratory System</b>                                                                                          |                          |                                     |
| Asthma /Chronic Cough / Pneumoconiosis                                                                                       | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Tuberculosis or Pneumonia                                                                                                    | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <b>2.4 Upper Respiratory System</b>                                                                                          |                          |                                     |
| ENT (Ear, Nose & Throat) disorders                                                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Hearing or Speech Disorders                                                                                                  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <b>2.5 Dermatology / Muscular Skeletal System</b>                                                                            |                          |                                     |
| Malignant Tumours or Cancer                                                                                                  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Skin Disorders (Psoriasis, Eczema, Acne) that may prevent the use of work clothing or PPE                                    | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Disease of Muscle, Bone, Joints, back                                                                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <b>2.6 Urinary &amp; Reproductive System</b>                                                                                 |                          |                                     |
| Kidney Stone or Urinary Infections                                                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Prostate / Gynaecological Problems                                                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Are you pregnant (females only)                                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <b>2.7 Abdominal</b>                                                                                                         |                          |                                     |
| Heartburn, Frequent Indigestion                                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Stomach, Liver, or Intestinal trouble                                                                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Bleeding from the Rectum                                                                                                     | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <b>2.8 Endocrine</b>                                                                                                         |                          |                                     |
| Diabetes Mellitus (sugar sickness)                                                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Thyroid disease, glandular disorder,                                                                                         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Blood Diseases                                                                                                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <b>2.9 Gynaecology- Obstetrics (Female applicants only)</b>                                                                  |                          |                                     |
| Are you pregnant?                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/>            |
| If yes, please indicate the age of pregnancy:                                                                                |                          |                                     |
| Any pregnancy complications?                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/>            |
| <b>2.10 Others</b>                                                                                                           |                          |                                     |
| Admission to hospital for any reason                                                                                         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Any Surgery / Operation                                                                                                      | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Any tropical disease e.g., bilharzias or malaria                                                                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> |



|                                                                                   |                                                                                                                                       |                |                 |
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|                                                                                                                                                                                                                           |                                     |                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|
| Eye problems                                                                                                                                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Any teeth problems                                                                                                                                                                                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Any auto-immune disorders                                                                                                                                                                                                 | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Blood coagulation disorders                                                                                                                                                                                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Organ Transplant                                                                                                                                                                                                          | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Cancer, growth, or tumour of any kind                                                                                                                                                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Do you think your current workplace may be affecting your health?                                                                                                                                                         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Unexplained Weight-loss or Gain                                                                                                                                                                                           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Provide further comment for items marked "YES"                                                                                                                                                                            |                                     |                                     |
|                                                                                                                                                                                                                           |                                     |                                     |
| <b>3. Social History</b>                                                                                                                                                                                                  | YES                                 | NO                                  |
| Alcohol                                                                                                                                                                                                                   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| <i>once in a month</i><br>If yes, how many grams per week (10g = 1 can beer = 1 glass wine = 1 glass/nip spirit)                                                                                                          |                                     |                                     |
| Recreational drugs                                                                                                                                                                                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| If yes, please specify:                                                                                                                                                                                                   |                                     |                                     |
| Exercise, sport                                                                                                                                                                                                           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| If yes, please provide type and frequency?<br><i>Docece everyday</i>                                                                                                                                                      |                                     |                                     |
| Smoking:                                                                                                                                                                                                                  | Never                               | <input type="checkbox"/>            |
|                                                                                                                                                                                                                           | Ex Smoker                           | <input type="checkbox"/>            |
|                                                                                                                                                                                                                           | Smoker                              | <input checked="" type="checkbox"/> |
| <i>one packet per day</i><br>If Smoker, how many cigarettes per day                                                                                                                                                       |                                     |                                     |
| <b>4 Psychological Screening</b>                                                                                                                                                                                          | YES                                 | NO                                  |
| Have you ever been advised not to work on heights, do shift work, night work, or any kind of work                                                                                                                         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Do you or did you ever have any nervous or mental complaint, e.g. Epilepsy, Blackouts, Dizzy spells, Episodes of sudden weakness, anxiety or Depression                                                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Have you ever been referred to a specialist, particularly a psychologist or psychiatrist or any other health professional for medical evaluation, opinion or treatment involving your mental functions or emotional state | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Do you have a fear of heights or enclosed spaces                                                                                                                                                                          | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Are you aware of any other problems that could affect your ability to safely perform expected duties working on heights / in enclosed spaces                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Have you been informed of tasks you are expected to perform and safety requirements for working on heights / in enclosed spaces                                                                                           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Have you ever attempted suicide or had suicidal thoughts                                                                                                                                                                  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |



|                                                                                                                                                                     |                                                                              |          |                 |                |
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|                                                                                                      |                          |                                     |
|------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|
| Do you often feel sad, depressed, or hopeless                                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Do you often have thoughts that are not your own, e.g.: message from the gods, devil or evil spirits | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Do you consider yourself to have special powers, e.g.: you can fly without any wings or help         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Do you often feel irritable; feel that everything is an effort                                       | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Do you often feel nervous, or have no control over your worries                                      | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Are you known to start arguments                                                                     | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Do you often feel restless or on the edge                                                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Provide further comment for items marked "YES"

| 5. | Respiratory/ TB Questionnaire                                                                                           | YES                      | NO                                  |
|----|-------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|
|    | Do you usually cough first thing in the morning                                                                         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Do you usually cough during the day or night                                                                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Do you usually bring up any phlegm during the day or night                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Have you ever coughed up blood                                                                                          | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Does your chest ever feel tight, or your breathing become difficult                                                     | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill                       | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Is your breathlessness worse on any day                                                                                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Does your chest ever sound wheezy or whistling                                                                          | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | During the past 3 years have you had any chest illness which kept you away from your usual duties for as much as a week | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Have you ever had an injury or operation affecting your chest                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Have you ever had heart trouble                                                                                         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Have you ever had Bronchitis, Pneumonia, Pleurisy                                                                       | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
|    | Have you ever had Pulmonary Tuberculosis, Asthma, or other respiratory condition                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Provide further comment for items marked "YES"

|                                                                               |            |
|-------------------------------------------------------------------------------|------------|
| 6                                                                             | Medication |
| Please state the type and dosages of all medications you are currently taking |            |
|                                                                               |            |
| 7                                                                             | Allergies  |

|                                                                                   |                                                                                                                                       |                |                 |
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**Please state if you have any allergies:**

Food:

Medication: *Amoxicillin*

Chemical:

Other:

### 3- OCCUPATIONAL HEALTH QUESTIONNAIRE:

| <b>Have you been in a job where you have been exposed to:</b>                                            |                          |                                     |                            |                          |                                     |
|----------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|----------------------------|--------------------------|-------------------------------------|
| Exposure agent                                                                                           |                          |                                     | Date/ Duration of exposure | Protection used          |                                     |
|                                                                                                          | YES                      | NO                                  |                            | YES                      | NO                                  |
| Chemicals                                                                                                | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | <input type="checkbox"/> | <input type="checkbox"/>            |
| If "YES" please specify                                                                                  |                          |                                     |                            |                          |                                     |
| Noise                                                                                                    | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Vibrations                                                                                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Radiation                                                                                                | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Biological                                                                                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Asbestos Dust                                                                                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Lead exposure                                                                                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Other Dust (silica, coal, gold, diamond)                                                                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | <input type="checkbox"/> | <input type="checkbox"/>            |
| If a protection was used for the above hazards, please specify.                                          |                          |                                     |                            |                          |                                     |
| Have you been absent from work in the last year?                                                         |                          |                                     |                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If yes, for how long and what were the causes?                                                           |                          |                                     |                            |                          |                                     |
| Have you ever had a work-related injury or illness or worker's compensation claim? If yes, please state: |                          |                                     |                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| The cause (s) of the illness or injury                                                                   |                          |                                     |                            |                          |                                     |
| The medical treatment which you undertook and / or continue to undertake                                 |                          |                                     |                            |                          |                                     |
| Do you continue to suffer from the effects of a work-related injury or illness: YES NO                   |                          |                                     |                            |                          |                                     |
| If you do, state the symptoms that you continue to suffer:                                               |                          |                                     |                            |                          |                                     |
| Do you continue to suffer from the effects of a work-related injury or illness:                          |                          |                                     |                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If you do, state the symptoms that you continue to suffer:                                               |                          |                                     |                            |                          |                                     |
| Does the nature of your work involve the following?                                                      |                          |                                     |                            | YES                      | NO                                  |



|                                                                                   |                                                                              |                |                 |
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|                                             |                          |                                     |
|---------------------------------------------|--------------------------|-------------------------------------|
| Driving heavy earthmoving equipment         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Repetitive lifting/ bending                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Working on surface in light physical duties | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Prolonged standing posture                  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Passengers' vehicle driving                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Office work                                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Confined Space                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Working at heights                          | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| In contact with wildlife                    | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Working Offshore                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Working underground                         | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Hot work area                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

#### APPLICANT'S STATEMENT:

I declare that the answers to all questions are to the best of my knowledge correct and that I have not withheld any information regarding my past or present health.

Print Name: LiPeng

Signature: 李鹏

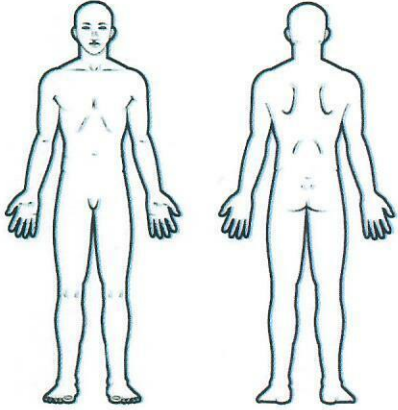
Date: 10/6/2024

|                                                                                   |                                                                               |                |                 |              |                |
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#### 4- PHYSICAL EXAMINATION:

**To be completed by the examining doctor** Careful examination of all systems is requested, and all sections should be completed.

|                       |              |    |    |                   |                                             |                                    |     |
|-----------------------|--------------|----|----|-------------------|---------------------------------------------|------------------------------------|-----|
| Height                | 1,70         | cm | Ft | Weight            | 87                                          | Kg                                 | Lbs |
| BMI (body mass Index) | 23,18        |    |    | Temperature       | 36,5                                        | °C                                 | °F  |
| Blood pressure        | 120/77 mmHg  |    |    | Respiratory rate: | 22 y / mn                                   |                                    |     |
| Pulse rate            | 58 beat / mn |    |    | Pulse rhythm      | Regular <input checked="" type="checkbox"/> | Irregular <input type="checkbox"/> |     |

|                                | Normal                              | Abnormal                 |                                                                                     |
|--------------------------------|-------------------------------------|--------------------------|-------------------------------------------------------------------------------------|
| Eyes                           | <input checked="" type="checkbox"/> | <input type="checkbox"/> |  |
| Ear, Nose and Throat           | <input checked="" type="checkbox"/> | <input type="checkbox"/> |                                                                                     |
| Teath and Mouth                | <input checked="" type="checkbox"/> | <input type="checkbox"/> |                                                                                     |
| Respiratory                    | <input checked="" type="checkbox"/> | <input type="checkbox"/> |                                                                                     |
| Cardiovascular                 | <input checked="" type="checkbox"/> | <input type="checkbox"/> |                                                                                     |
| Abdominal                      | <input checked="" type="checkbox"/> | <input type="checkbox"/> |                                                                                     |
| Musculoskeletal                | <input checked="" type="checkbox"/> | <input type="checkbox"/> |                                                                                     |
| Extremities                    | <input checked="" type="checkbox"/> | <input type="checkbox"/> |                                                                                     |
| Genitourinary                  | <input checked="" type="checkbox"/> | <input type="checkbox"/> |                                                                                     |
| Comments on clinical findings: |                                     |                          |                                                                                     |

#### 5- VISION EXAMINATION:

| Vision: | Without Spectacles |        | With Spectacles | Colour Vision:                                                                                               |
|---------|--------------------|--------|-----------------|--------------------------------------------------------------------------------------------------------------|
|         | Far                | Near   |                 |                                                                                                              |
|         |                    |        |                 | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Red/Green <input type="checkbox"/> Other |
| Right   | 6/ 310             | 6/ 310 | 6/              | Visual Fields: normal                                                                                        |



|                                                                                                                                                                     |                                                                              |                |                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------|-----------------|
|   | <h2 style="color: #0070C0;">HSEC Management System</h2>                      | Doc. No.       | HSEC_FOR 031023 |
|                                                                                                                                                                     |                                                                              | Version:       | 1.0             |
|                                                                                                                                                                     |                                                                              | Reviser:       | Sofiane Chebli  |
|                                                                                                                                                                     |                                                                              | Approved by:   | John Perry      |
|                                                                                                                                                                     |                                                                              | Approval date: | 21/11/2023      |
|                                                                                    | <b>Simandou project</b><br><b>Medical Assessment_Long stay_International</b> |                |                 |

|      |        |        |    |                                                                              |
|------|--------|--------|----|------------------------------------------------------------------------------|
| Left | 6/ 810 | 6/ 810 | 6/ | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
|------|--------|--------|----|------------------------------------------------------------------------------|

### 6- LABORATORY ANALYSIS:

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

**BLOOD GROUP**  
Test if not already known

B Rh +

### URINALYSIS:

|           |       |           |       |
|-----------|-------|-----------|-------|
| Glucose   | NEANT | Blood     | NEANT |
| Bilirubin | NEANT | Leucocyts | NEANT |
| Ketone    | NEANT | Protein   | NEANT |

### BLOOD TESTS:

|                               |                                            |                                               |
|-------------------------------|--------------------------------------------|-----------------------------------------------|
| Total blood count             | <input type="checkbox"/> Normal            | <input checked="" type="checkbox"/> Abnormal: |
| Electrolytes                  | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal:            |
| Fasting blood sugar           | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal:            |
| Urea                          | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal:            |
| Creatinine                    | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal:            |
| Bilirubin                     | <input type="checkbox"/> Normal            | <input type="checkbox"/> Abnormal:            |
| Cholesterol (Total, HDL, LDL) | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal:            |
| Triglycerides                 | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal:            |
| ALAT- ASAT                    | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal:            |
| Gamma GT                      | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Abnormal:            |
| CRP                           | <input type="checkbox"/> Normal            | <input type="checkbox"/> Abnormal:            |

### URINE DRUG SCREENING:

|                                                                                                                                                                     |                               |          |                 |                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------|-----------------|----------------|
|   | <b>HSEC Management System</b> | Doc. No. | HSEC FOR 031023 |                |
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|                                                                                    |                               |          | Reviser:        | Sofiane Chebli |
|                                                                                                                                                                     |                               |          | Approved by:    | John Perry     |
|                                                                                                                                                                     |                               |          | Approval date:  | 21/11/2023     |
| <p align="center"><b>Simandou project</b></p> <p align="center"><b>Medical Assessment_Long stay_International</b></p>                                               |                               |          |                 |                |

|                 |                                              |                                   |
|-----------------|----------------------------------------------|-----------------------------------|
| Amphetamines    | <input checked="" type="checkbox"/> Negative | <input type="checkbox"/> Positive |
| benzodiazepines | <input checked="" type="checkbox"/> Negative | <input type="checkbox"/> Positive |
| cannabinoids    | <input checked="" type="checkbox"/> Negative | <input type="checkbox"/> Positive |
| opiates         | <input checked="" type="checkbox"/> Negative | <input type="checkbox"/> Positive |
| Cocaine         | <input checked="" type="checkbox"/> Negative | <input type="checkbox"/> Positive |



|                                                                                   |                                                                               |                       |                 |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------|-----------------|
|  | <h2 style="margin: 0;">HSEC Management System</h2>                            | <b>Doc. No.</b>       | HSEC FOR 031023 |
|                                                                                   |                                                                               | <b>Version:</b>       | 1.0             |
|                                                                                   |                                                                               | <b>Reviser:</b>       | Sofiane Chebli  |
|                                                                                   |                                                                               | <b>Approved by:</b>   | John Perry      |
|                                                                                   |                                                                               | <b>Approval date:</b> | 21/11/2023      |
|  | <h3>Simandou project</h3> <h3>Medical Assessment_Long stay_International</h3> |                       |                 |

#### CHEST X RAY

|                                                                                           |
|-------------------------------------------------------------------------------------------|
| <b>Findings:</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal: |
|-------------------------------------------------------------------------------------------|

#### RESTING ECG (Please attached the ECG strip).

|                                                                                           |
|-------------------------------------------------------------------------------------------|
| <b>Findings:</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal: |
|-------------------------------------------------------------------------------------------|

#### STRESS ECG (if clinically indicated)

|                                                                                           |
|-------------------------------------------------------------------------------------------|
| <b>Findings:</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal: |
|-------------------------------------------------------------------------------------------|

#### SPIROMETRY: Please attach the full report

|                                             | FVC    | FEV 1 | FEV % |
|---------------------------------------------|--------|-------|-------|
| Measured                                    | 4,90   | 3,52  | 71,84 |
| Predicted                                   | 4,47   | 3,71  | 81,82 |
| % Predicted                                 | 109,62 | 94,88 | 86,72 |
| Refer if FEV 1 /FVC ratio < 70%             |        |       |       |
| <b>Comment in full on any abnormalities</b> |        |       |       |

#### AUDIOMETRY: Please attach the audiogram

|  | Normal | Abnormal | Comment |
|--|--------|----------|---------|
|--|--------|----------|---------|

|                                                                                   |                                                                              |                |                 |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------|-----------------|
|  | <b>HSEC Management System</b>                                                | Doc. No.       | HSEC FOR 031023 |
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|                                                                                   |                                                                              | Approved by:   | John Perry      |
|                                                                                   |                                                                              | Approval date: | 21/11/2023      |

|           |                                     |                          |  |
|-----------|-------------------------------------|--------------------------|--|
| Left Ear  | <input checked="" type="checkbox"/> | <input type="checkbox"/> |  |
| Right Ear | <input checked="" type="checkbox"/> | <input type="checkbox"/> |  |
| PLH:      | %                                   |                          |  |

#### VACCINATION:

The Applicant will be traveling to Guinea, West Africa. It is a high-risk country for several infectious and tropical diseases. **Please indicate the vaccination status of the applicant and any administered vaccine.**

A copy of the "International Certificate of Vaccination Booklet" or "The Immunization Record Card" must be attached to this form. Please outline the role and importance of vaccinations. If a vaccination is refused, please indicate in the comments section below.

| Vaccination                | Immune                   | Date | Comments |
|----------------------------|--------------------------|------|----------|
| <b>Mandatory:</b>          |                          |      |          |
| Yellow Fever               | <input type="checkbox"/> |      |          |
| <b>Highly recommended:</b> |                          |      |          |
| Covid 19                   | <input type="checkbox"/> |      |          |
| Hepatitis A                | <input type="checkbox"/> |      |          |
| Hepatitis B                | <input type="checkbox"/> |      |          |
| Tetanus                    | <input type="checkbox"/> |      |          |
| Polio                      | <input type="checkbox"/> |      |          |
| Typhoid                    | <input type="checkbox"/> |      |          |
| Meningococcal              | <input type="checkbox"/> |      |          |
| Diphtheria                 | <input type="checkbox"/> |      |          |
| Rabies*                    | <input type="checkbox"/> |      |          |

(\*) Highly recommended to applicants who may be in contact with wildlife as part of their work nature.

|                                                                                                                                                                                                                                                                                                                                                                           |            |       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------|
| <b>Statement:</b> to be signed by the Applicant if they decline a vaccination<br><i>"I hereby declare that I declined the administration of the vaccine(s) stated above, after I was made aware of their recommendation and considering Guinea's high epidemiological risk profile. My decision was made after I received all the information related to the vaccine"</i> |            |       |
| Print Name:                                                                                                                                                                                                                                                                                                                                                               | Signature: | Date: |

#### MALARIA CHEMOPROPHYLAXIS



|                                                                                   |                                                                              |                |                 |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------|-----------------|
|  | <b>HSEC Management System</b>                                                | Doc. No.       | HSEC FOR 031023 |
|                                                                                   |                                                                              | Version:       | 1.0             |
|  | <b>Simandou project</b><br><b>Medical Assessment_Long stay_International</b> | Reviser:       | Sofiane Chebli  |
|                                                                                   |                                                                              | Approved by:   | John Perry      |
|                                                                                   |                                                                              | Approval date: | 21/11/2023      |

**Malaria chemoprophylaxis is highly recommended.**

**Please provide general information on preventive measures to avoid mosquito bites and how to recognise early signs of Malaria. Please prescribe sufficient medication to cover the duration of stay in Guinea.**

|                                      |                                     |
|--------------------------------------|-------------------------------------|
| Malarone                             | <input type="checkbox"/> Prescribed |
| <input type="checkbox"/> Doxycycline | <input type="checkbox"/> Procured   |
| <input type="checkbox"/> Other       | <input type="checkbox"/> Declined   |