





MV/RT/152

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		Version:	1.0
	Simandou Project Medical Assessment Annual International	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 for review and approval.

For ongoing health surveillance, and as per the Guinean labour law, an annual medical examination is required. The personal data requested on this form includes detailed health information about you and is required for the purposes of:

- determining if you are still fit to work on the Simandou project.
- ensuring your vaccinations are up to date.
- Identifying any medical condition that may have arisen since joining the Simandou project and any assessing any occupational implications.

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 or email 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

Print Name: BUCZYNSKI ROMAN

Signature: 

Date: 11/06/2024

CONFIDENTIAL

The completed Form is to be emailed to the Simfer Medical Team: Simfermedicalteam@riotinto.com

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

First and Last Name	BUCZYNSKI ROMAN		Date of Birth	03-06-1985
Nationality	BRITISH CITIZEN			
Company	RIO TINTO			
Indicate Job/Position	SENIOR SECURITY SUPERINTENDANT MINE			
Purpose of the travel	WORK			
Home address	KALOUM			
Home Phone		Mobile Phone	611007363	
Passport /ID Number	137320579	Expiry Date	27-01-2033	
Email				
Emergency Contact	Name	EWA BUCZYNSKI		
	Phones	+441422202167		
	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 checked="" type="checkbox"/>	<input 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" <i>Mother : High blood pressure</i>		
2.	Medical History	YES	NO
2.1	Central Nervous System		
	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 type="checkbox"/>

2.2	Cardiovascular System		
	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"/>
2.3	Lower Respiratory System		
	Asthma /Chronic Cough / Pneumoconiosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Tuberculosis or Pneumonia	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.4	Upper Respiratory System		
	ENT (Ear, Nose & Throat) disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Hearing or Speech Disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.5	Dermatology / Muscular Skeletal System		
	Malignant Tumours or Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Skin Disorders (Psoriasis, Eczema, Acne)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Disease of Muscle, Bone, Joints, back	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.6	Urinary & Reproductive System		
	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 type="checkbox"/>
2.7	Abdominal		
	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"/>
2.8	Endocrine		
	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"/>
2.9	Gynaecology- Obstetrics (Female applicants only)		
	Are you pregnant?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	If yes, please indicate the age of pregnancy:		
	Any pregnancy complications?	<input type="checkbox"/>	<input type="checkbox"/>
2.10	Others		
	Admission to hospital for any reason	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Any Surgery / Operation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Any tropical disease e.g., bilharzias or malaria	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	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"

20-Right Knee ACL re-done

3. Social History

YES NO

Alcohol

☒

☐

If yes, how many grams per week (10g = 1 can beer = 1 glass wine = 1 glass/nip spirit)

100g

Recreational drugs

☐

☒

If yes, please specify:

Exercise, sport

☒

☐

If yes, please provide type and frequency?

7 x A week minimum

Smoking:

Never

☒

☐

Ex Smoker

☐

☐

Smoker

☐

☐

If Smoker, how many cigarettes per day

4. Medication

Please state the type and dosages of all medications you are taking

- 10mg Amlodipine p/d
- 100mg x 2 Allopurinol p/d

5. Allergies

Please state if you have any allergies:

Food: N/A

Medication: N/A

Chemical: N/A

Other:

APPLICANT'S STATEMENT:

I hereby 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: R. BUZYNSKI

Signature:



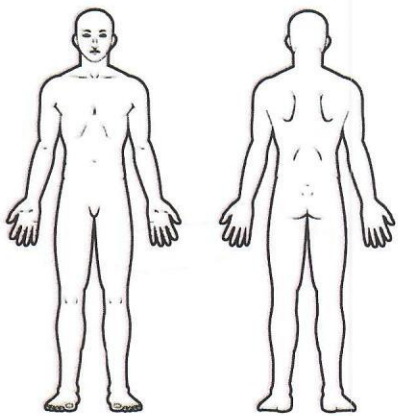
Date: 11/09/24

4- PHYSICAL EXAMINATION:

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

Height	175	Cm		Ft		Weight	82	Kg		Lbs	
BMI (body mass Index)	26.77					Temperature	37	°C	<input type="checkbox"/>	°F	<input type="checkbox"/>
Blood pressure	153/87					Respiratory rate:				18 cycles/min	
Pulse rate	60 bpm					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"/>
Teeth and Mouth	<input type="checkbox"/>	<input checked="" 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: Denture incomplete.

5- LABORATORY ANALYSIS:

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

BLOOD TESTS:

Total blood count	<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:

RESTING ECG (if clinically indicated). Please attached the ECG strip.

Findings: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:

VISION EXAMINATION:

Vision:	Without Spectacles		With Spectacles	Colour Vision:
	Far	Near		<input checked="" type="checkbox"/> Normal <input checked="" type="checkbox"/> Red/Green <input type="checkbox"/> Other
Right	6/ 9/10	6/ 8/10	6/	Visual Fields: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Left	6/ 9/10	6/ 8/10	6/	

SPIROMETRY: (for job positions that require it) otherwise every 2 years. Please attach full report

	FVC	FEV 1	FEV %
Measured			
Predicted			
% Predicted			
Refer if FEV 1 /FVC ratio > 70%			
Comment in full on all abnormalities			

AUDIOMETRY: (if exposed to noise > 85 dB) every 2 years

Please attach the full audiogram report

	Normal	Abnormal	Comment
Left Ear	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Right Ear	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
PLH: %			

VACCINATION:

Guinea 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
Mandatory:			
Yellow Fever	<input type="checkbox"/>		
Highly recommended:			
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.

Statement: to be signed by the Applicant if they decline a vaccination

"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"

Print Name:

Signature:

Date:

MALARIA CHEMOPROPHYLAXIS

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.

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