

YINBT 112

|                                                                                  |                                                                                   |                                                             |              |                 |            |
|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------|--------------|-----------------|------------|
|  |  | <h2 style="text-align: center;">HSEC Management System</h2> | Doc. No.     | HSEC FOR 031030 |            |
|                                                                                  |                                                                                   |                                                             | Version:     | 1.0             |            |
|                                                                                  |                                                                                   |                                                             | Reviser:     | Sofiane Chebli  |            |
|                                                                                  |                                                                                   |                                                             | Approved by: | John Perry      |            |
|                                                                                  |                                                                                   |                                                             |              | Approval date:  | 21/11/2023 |
|  | <h3>Simandou Project</h3> <h3>Medical Assessment Annual International</h3>        |                                                             |              |                 |            |

**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.

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.

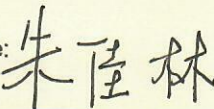
The purpose of requiring this information is because working in Guinea poses significant health risks. This includes limited access to medical facilities and services, exposure to a range of vector borne and infectious diseases, and delays in medical evacuation should it be required. These factors may 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](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 |
|---------------------|------------------------------------------------------------------------------------------------|------------------|



## 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   |               |            |
| Company               | RIO TINTO |               |            |
| Indicate Job/Position | ADVISOR   |               |            |
| Purpose of the travel | WORK      |               |            |
| Home address          | CANGA     |               |            |
| Home Phone            | 627496526 | Mobile Phone  | 612004980  |
| Passport /ID Number   | PE2306946 | Expiry Date   | 16/06/2028 |
| 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?*

|            |                                                              |                          |                                     |
|------------|--------------------------------------------------------------|--------------------------|-------------------------------------|
| <b>1.</b>  | <b>Family History (Parents)</b>                              | <b>YES</b>               | <b>NO</b>                           |
|            | 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"               |                          |                                     |
|            |                                                              |                          |                                     |
| <b>2.</b>  | <b>Medical History</b>                                       | <b>YES</b>               | <b>NO</b>                           |
| <b>2.1</b> | <b>Central Nervous System</b>                                |                          |                                     |
|            | 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</b>  | <b>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</b>  | <b>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</b>  | <b>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</b>  | <b>Dermatology / Muscular Skeletal System</b>                                                                                |                          |                                     |
|             | 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"/> |
| <b>2.6</b>  | <b>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</b>  | <b>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</b>  | <b>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</b>  | <b>Gynaecology- Obstetrics (Female applicants only)</b>                                                                      |                          |                                     |
|             | 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 checked="" type="checkbox"/> |
| <b>2.10</b> | <b>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"/> |
|             | 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"

3. Social History

YES

NO

Alcohol

once in a month

☒

☐

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

Recreational drugs

☐

☒

If yes, please specify:

Exercise, sport

☒

☐

If yes, please provide type and frequency?

Dollar everyday

Smoking:

Never

☐

☐

Ex Smoker

☐

☐

Smoker

☒

☐

If Smoker, how many cigarettes per day

One packet per day

4. Medication

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

one packet per day

5. Allergies

Please state if you have any allergies:

Food:

Medication:

Amoxicillin

Chemical:

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:

Signature:

朱廷林

Date:

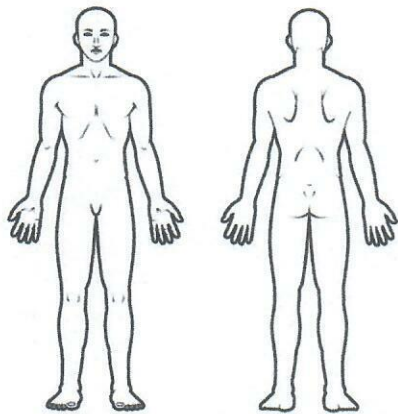


#### 4- PHYSICAL EXAMINATION:

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

|                       |              |    |  |    |  |                   |        |         |                          |           |                          |
|-----------------------|--------------|----|--|----|--|-------------------|--------|---------|--------------------------|-----------|--------------------------|
| Height                | 170          | Cm |  | Ft |  | Weight            | 62     | Kg      |                          | Lbs       |                          |
| BMI (body mass Index) | 23,8         |    |  |    |  | Temperature       | 36,5   | °C      | <input type="checkbox"/> | °F        | <input type="checkbox"/> |
| Blood pressure        | 120, 72 mmHg |    |  |    |  | Respiratory rate: | 22 cys |         |                          |           |                          |
| Pulse rate            | 58 bpm       |    |  |    |  | Pulse rhythm      |        | Regular | <input 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- LABORATORY ANALYSIS:

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

#### BLOOD TESTS:

|                               |                                            |                                               |
|-------------------------------|--------------------------------------------|-----------------------------------------------|
| Total blood count             | <input type="checkbox"/> Normal            | <input checked="" 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:**

- ☐ Normal  
☐ Abnormal:

**VISION EXAMINATION:**

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

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

|                                      | FVC    | FEV 1 | FEV % |
|--------------------------------------|--------|-------|-------|
| Measured                             | 4,80   | 3,52  | 71,84 |
| Predicted                            | 6,67   | 3,71  | 81,82 |
| % Predicted                          | 109,62 | 94,88 | 86,72 |
| 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 type="checkbox"/> Doxycycline | <input type="checkbox"/> Procured   |
| <input type="checkbox"/> Other       | <input type="checkbox"/> Declined   |