

MV/WELHY/207

RioTinto

SimFer

HSEC Management  
System

Doc. No.

HSEC\_FOR 031023

Version:

1.0

Reviser:

Sofiane Chebli

Approved by:

John Perry

Approval date:

21/11/2023

Simandou project  
Medical Assessment\_Long stay\_International

## 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: AGOFOUNTO Timothe

Signature: 

Date: 02/07/2024



 	<h2 style="text-align: center;">HSEC Management System</h2>	Doc. No.	HSEC FOR 031023
		Version:	1.0
	<h3 style="text-align: center;">Simandou project 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	AGOFOUNTO TIMOTHEE		Date of Birth	30/10/1981
Nationality	BENINOISE			
Employer	WELHY-CIS			
Indicate Job/Position	CHEF PATISSIER			
Purpose of the travel	PRE-EMBAUHE			
Home address	CANGA			
Home Phone		Mobile Phone	622614826	
Passport /ID Number	XXXXX	Expiry Date	XXXX	
Email				
Emergency Contact	Name	LETTE OMONBOGO		
	Phones	622820445		
	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?*

	YES	NO
<b>1. Family History (Parents)</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"		
	YES	NO
<b>2. Medical History</b>		
<b>2.1 Central Nervous System</b>		



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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			
<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			
<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) that may prevent the use of work clothing or PPE		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Disease of Muscle, Bone, Joints, back			
<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 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 checked="" type="checkbox"/>	<input 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			
<b>2.9</b>	<b>Gynaecology- Obstetrics (Female applicants only)</b>		
Are you pregnant?		<input type="checkbox"/>	<input type="checkbox"/>
If yes, please indicate the age of pregnancy:		<input type="checkbox"/>	<input type="checkbox"/>
Any pregnancy complications?			
<b>2.10</b>	<b>Others</b>		
Admission to hospital for any reason		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Any Surgery / Operation		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Any tropical disease e.g., bilharzias or <u>malaria</u>		<input checked="" type="checkbox"/>	<input type="checkbox"/>



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Eye problems

Any teeth problems

Any auto-immune disorders

Blood coagulation disorders

Organ Transplant

Cancer, growth, or tumour of any kind

Do you think your current workplace may be affecting your health?

Unexplained Weight-loss or Gain

Provide further comment for items marked "YES"

Ulcer, Hospitalisé suite à un  
accident de la route en 2009 ainsi 1996 sans séquelle  
majeure.

## 3. Social History

Alcohol

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

3 bières occasionnellement.

Recreational drugs

If yes, please specify:

Exercise, sport

If yes, please provide type and frequency?

Vélo 5 fois/semaine.

Smoking:

Never

Ex Smoker

Smoker

If Smoker, how many cigarettes per day

## 4 Psychological Screening

Have you ever been advised not to work on heights, do shift work, night work, or any kind of work

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

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

Do you have a fear of heights or enclosed spaces

Are you aware of any other problems that could affect your ability to safely perform expected duties working on heights / in enclosed spaces

Have you been informed of tasks you are expected to perform and safety requirements for working on heights / in enclosed spaces

Have you ever attempted suicide or had suicidal thoughts



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Do you often feel sad, depressed, or hopeless

☐☒

Do you often have thoughts that are not your own, e.g.: message from the gods, devil or evil spirits

☐☒

Do you consider yourself to have special powers, e.g.: you can fly without any wings or help

☐☒

Do you often feel irritable; feel that everything is an effort

☐☒

Do you often feel nervous, or have no control over your worries

☐☒

Are you known to start arguments

☐☒

Do you often feel restless or on the edge

☐☒

Provide further comment for items marked "YES"

## 5. Respiratory/ TB Questionnaire

YES

NO

Do you usually cough first thing in the morning

☐☒

Do you usually cough during the day or night

☐☒

Do you usually bring up any phlegm during the day or night

☐☒

Have you ever coughed up blood

☐☒

Does your chest ever feel tight, or your breathing become difficult

☐☒

Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill

☐☒

Is your breathlessness worse on any day

☐☒

Does your chest ever sound wheezy or whistling

☐☒

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

☐☒

Have you ever had an injury or operation affecting your chest

☐☒

Have you ever had heart trouble

☐☒

Have you ever had Bronchitis, Pneumonia, Pleurisy

☐☒

Have you ever had Pulmonary Tuberculosis, Asthma, or other respiratory condition

☐☒

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:

Chemical:

Other:

### 3- OCCUPATIONAL HEALTH QUESTIONNAIRE:

Have you been in a job where you have been exposed to:					
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:

Signature:

Date:

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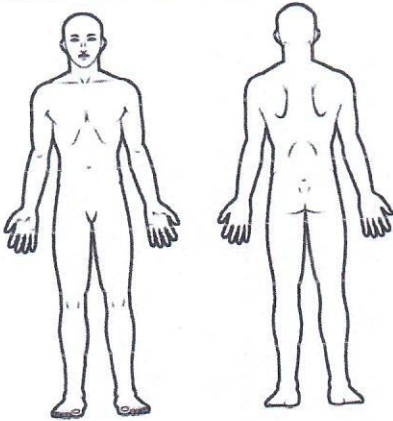
### Medical Assessment\_Long stay\_International

4- PHYSICAL EXAMINATION:

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

Height	167 cm	Ft	Weight	96 Kg	Lbs
BMI (body mass Index)	34.4		Temperature	°C 36.4	°F
Blood pressure	130/83 mmHg		Respiratory rate:	18 cycles	
Pulse rate	97 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"/>
Teath 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: *Pityriasis Versicolor, denture incomplete.*

5- VISION EXAMINATION:

Vision:	Without Spectacles		With Spectacles	Colour Vision:
	Far	Near		
Right	6/5/10	6/8/10	6/	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Red/Green <input type="checkbox"/> Other <i>Anormal</i>
Visual Fields:				



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Left	6/ 5/10	6/ 7/10	6/	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
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**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

snip**Rh**    O<sup>+</sup>

**URINALYSIS:**

Glucose	Nearnt	Blood	Nearnt
Bilirubin	Nearnt	Leucocyts	Nearnt
Ketone	Nearnt	Protein	Nearnt

**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 checked="" 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:**



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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



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#### CHEST X RAY

##### Findings:

- ☐ Normal
- ☐ Abnormal:

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

##### Findings:

- ☐ Normal
- ☐ Abnormal:

#### STRESS ECG (if clinically indicated)

##### Findings:

- ☐ Normal
- ☐ Abnormal:



#### SPIROMETRY: Please attach the full report

	FVC	FEV 1	FEV %
Measured	2,83	2,71	85,76
Predicted	4,45	3,67	82,24
% Predicted	63,60	73,84	716,44
Refer if FEV 1 /FVC ratio < 70%			
Comment in full on any abnormalities			

#### AUDIOMETRY: Please attach the audiogram

	Normal	Abnormal	Comment
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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 <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

<p><b>Malaria chemoprophylaxis is highly recommended.</b></p> <p>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.</p>
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Malarone	<input type="checkbox"/> Prescribed
<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Procured
<input type="checkbox"/> Other	<input type="checkbox"/> Declined