
	<p style="text-align: center;">HSEC Management System</p>	<table border="1"> <tr> <td>Doc. No.</td> <td>HSEC_FOR_031021</td> </tr> <tr> <td>Version:</td> <td>1.0</td> </tr> <tr> <td>Revised by:</td> <td>Sofiane Chebli</td> </tr> <tr> <td>Approved by:</td> <td>John Perry</td> </tr> <tr> <td>Approval date:</td> <td>21/11/2023</td> </tr> </table>	Doc. No.	HSEC_FOR_031021	Version:	1.0	Revised by:	Sofiane Chebli	Approved by:	John Perry	Approval date:	21/11/2023
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Version:	1.0											
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	<p style="text-align: center;">Simandou Project Medical Assessment_Short stay_International</p>											

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.

The personal data requested on this form (**your personal data**) includes detailed health information about you 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 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: SAMUEL MUSTAPHA	Signature: 	Date: 26/08/2024
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		Version:	1.0
	<h2 style="text-align: center;">Simandou Project</h2> <h3 style="text-align: center;">Medical Assessment_Short stay_International</h3>	Revised by:	Sofiane Chebli
		Approved by:	John Perry
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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	SAMUEL MUSTAPHA		Date of Birth	01/01/1989
Nationality	LEONNAISE			
Company	GUI-APEX			
Indicate Job/Position	TECHNICIEN			
Purpose of the travel	BEYLA			
Home address				
Home Phone		Mobile Phone	625237383	
Passport /ID Number	XXX	Expiry Date	XXX	
Email				
Emergency Contact	Name	OULARE MANSSO		
	Phones	626039972		
	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		YES	NO
			GASTROINTESTINAL		
CARDIOVASUCLAR					
High Blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart problem, chest pain or palpitation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
DVT (Deep Vein thrombosis)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Vomiting blood	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stomach or duodenal ulcer	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Implantable cardiac device	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Coronary bypass	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hernia	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pulmonary embolism	<input type="checkbox"/>	<input checked="" type="checkbox"/>	MUSCULOSKELETAL		
NEUROLOGICAL			Chronic back pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Sciatica, Lumbago	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Stroke	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Nervous disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Back or neck surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Migraine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hip abnormalities	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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RESPIRATORY	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Knee or ankle abnormalities	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	ENDOCRINE/ IMMUNE SYSTEM	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Any surgical procedure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Compromised immune system	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Do you drink Alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
How many / day:			How many?		
Do you have any allergies?				<input type="checkbox"/>	<input checked="" type="checkbox"/>
Provide further comment for items marked "YES"					
Do you exercise regularly? If yes, provide type and frequency.					
Jogging 1 fois / semaine					

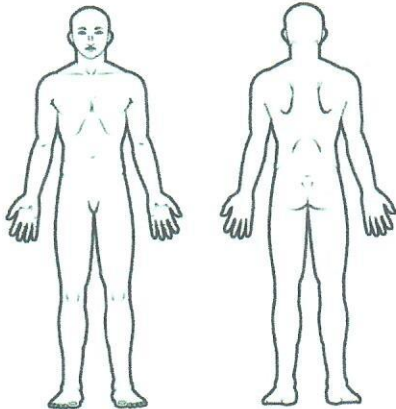
APPLICANT'S STATEMENT:		
I declare that the answers to all questions are to the best of my knowledge correct and that I have not withheld any information regarding my past or present health.		
Print Name:	Signature: 	Date:

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3- PHYSICAL EXAMINATION: To be completed by the examining doctor. Careful examination of all systems is requested, and all sections should be completed.

Height	1,72	cm	Ft	Weight	63	Kg	Lbs
BMI (body mass Index)	21,3			Temperature	36,9	°C	°F
Blood pressure	117/72			Respiratory rate:	21	cycles/min	
Pulse rate	59	bpm		Pulse rhythm	<input checked="" type="checkbox"/> Regular	<input type="checkbox"/> Irregular	

	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:

4- LABORATORY ANALYSIS:



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

BLOOD GROUP
Test if not already known

Rh AB⁺

URINALYSIS:

Glucose	Absence	Blood	Absence
Bilirubin	Absence	Leucocyts	Absence
Ketone	Absence	Protein	Absence

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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:
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:

VACCINATION:

<p>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.</p> <p>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.</p>
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Vaccination	Immune	Date	Comments
Mandatory:			
Yellow Fever	<input type="checkbox"/>		
Covid 19	<input type="checkbox"/>		
Highly recommended:			
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"/>		

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VACCINATION continued;

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