

# Prime Care 30

IMMEDIATE MEDICAL & DENTAL CARE CENTER  
**MEDICAL EXAMINATION RECORD**

Annual Physical Examination [ ]

Pre-Employment [ ]

Last Name ALIC First Name JOHN PAUL M.I. LLAGA Date 03-20-19  
 Address MINGLATNILLA, CEBU Age 21 Civil Status Married Sex Male  
 Place of Birth CEBU CITY Date of Birth 06-12-1997 Insurance Provider M  
 Occupation CALL CENTER AGENT Name of Company IPLOY Tel. / Mobile no. 0906-541-8002

**PHYSICAL EXAMINATION**

Temp.: 36.7°C PR: 69 bpm RR: 15 bpm BP: 120/80 mmHg Ht.: 163 cm Wt.: 70 kgs  
 Visual Acuity: Right Eye: 20/20 Left Eye: 20/20 BMI: 26.4  
 without eyeglasses  
 Underweight:  Overweight:   
 Normal Weight:  Obese:

**MEDICAL HISTORY**

Past Medical History: (-)  
 Family History: (-)  
 Previous Hospitalization: None  
 Menstrual History: (-) Parity: (-) LMP: (-) Contraceptive Use: (-)

Review of Systems	Normal	Findings	Review of Systems	Normal	Findings
Head & Scalp	<input checked="" type="checkbox"/>		Lungs	<input checked="" type="checkbox"/>	
Eyes & Ears	<input checked="" type="checkbox"/>		Heart	<input checked="" type="checkbox"/>	
Skin / Allergy	<input checked="" type="checkbox"/>		Abdomen	<input checked="" type="checkbox"/>	
Nose & Sinuses	<input checked="" type="checkbox"/>		Genitals	<input checked="" type="checkbox"/>	
Mouth / Teeth / Tongue	<input checked="" type="checkbox"/>		Extremities	<input checked="" type="checkbox"/>	
Neck / Nodes	<input checked="" type="checkbox"/>		Reflexes	<input checked="" type="checkbox"/>	
Chest/ Breast	<input checked="" type="checkbox"/>		BPE	<input checked="" type="checkbox"/>	

Laboratory	Normal	Findings	Laboratory	Normal	Findings
Chest X-Ray	<input checked="" type="checkbox"/>		ECG	<input checked="" type="checkbox"/>	
CBC	<input checked="" type="checkbox"/>		Other Procedures:	<u>NA</u>	
Urinalysis	<input checked="" type="checkbox"/>				
Fecalysis	<input checked="" type="checkbox"/>				
Drug Test	<u>NA</u>				

I certify that I have examined and found the employee to be physically [ ] Fit [ ] Unfit for employment.

Classification:

[ ] CLASS A Physically fit for all types of work

CLASS B Physically fit for all types of work  
 Has minor ailment/ defect. Easily curable or offers no handicap to job applied.  
 Needs treatment/ correction Overweight  
 [ ] Treatment optional for: \_\_\_\_\_

[ ] CLASS C Physically fit for less strenuous type of work. Has minor ailments/ defects.  
 Easily curable or offers no handicap to job applied.  
 [ ] Needs treatment/ correction \_\_\_\_\_  
 [ ] No treatment needed for: \_\_\_\_\_

[ ] CLASS D Employment at the risk and discretion of the management

[ ] CLASS E Unfit for employment

[ ] PENDING For further evaluation of: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date Examined

\_\_\_\_\_  
Medical Examiner  
License No.: \_\_\_\_\_



# Medgrupp Polyclinics & Diagnostic Center, Inc.

IMMEDIATE MEDICAL AND DENTAL CARE CENTER

2nd Level, APM Centrale, A. Soriano Jr. Ave., N.R.A. Mabaldo, Cebu City, 6000 Philippines  
Tel Nos. (032) 232-2273 \* (032) 266-3245

No.: 160215

LABORATORY DEPARTMENT  
License TO OPERATE No.: 07-085-17-AS-2

SO No.: 00746057

Name: ALICO, JOHN PAUL LLGA Age: 25 yrs. Date: 3/20/2019  
Physician: IPLOY INC., Patient Status: Sex: MALE  
Company: IPLOY INC.,  
Charge To: IPLOY INC.,

## URINALYSIS

### MACROSCOPIC:

Color	Yellow
Appearance	Clear
pH	6.0
Specific Gravity	1.020
Glucose	Negative
Protein	Negative

### MICROSCOPIC:

RBC / hpf	0-1
WBC / hpf	0-1
Epith. Cells / hpf	Rare
Casts	
Mucus Threads	Rare
Bacteria	Rare
Crystals	
Amorphous (Urates)	Rare
Amorphous (PO <sub>4</sub> )	
MISCELLANEOUS:	
Pregnancy Test	N/A
OTHERS:	

NOTE:

\_\_\_\_\_

*AK*

AIRA P. BALANSAG, RMT PRC#80834

Medical Technologist

*PK*  
PETER S. AZNAR, M.D., F.P.S.P.  
Pathologist  
PRC #72410



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2nd Level, APM Centrale, A. Soriano Jr. Ave., N.R.A. Mabaldo, Cebu City, 6000 Philippines  
Tel Nos. (032) 232-2273 \* (032) 266-3245

No.: 162639

LABORATORY DEPARTMENT  
License TO OPERATE No.: 07-085-17-AS-2

SO No.: 00746057

Name: ALICO, JOHN PAUL LLGA Age: 25 yrs. Date: 3/20/2019  
Requested by: Patient Status: Sex: MALE  
Company: IPLOY INC.,  
Charge To: IPLOY INC.,

## COMPLETE BLOOD COUNT

( ) WBC	6,000 /mm <sup>3</sup>	5,000-10,000 /mm <sup>3</sup>	Normal Values
( ) RBC	5.25 x 10 <sup>6</sup> /mm <sup>3</sup>		

Adult	F: 4.2 - 5.4 X 10 <sup>6</sup> /mm <sup>3</sup>
	M: 4.7 - 6.10 X 10 <sup>6</sup> /mm <sup>3</sup>
Pedia	F: 4.0 - 5.1 X 10 <sup>6</sup> /mm <sup>3</sup>
	M: 4.0 - 5.3 x 10 <sup>6</sup> /mm <sup>3</sup>

( ) Hemoglobin	15.76 gm%	F: 12-15gm% M: 14-17gm%
( ) Hematocrit	47.30 gm%	F: 38-48vol% M: 40-50vol%

### Differential Count

Neutrophils	60 %	45-65%
Lymphocytes	33 %	20-35%
Monocytes	4 %	2-9%
Eosinophils	3 %	0-6%
Basophils	%	0-2%
Platelet Count	320,000 /mm <sup>3</sup>	150,000-450,000 /mm <sup>3</sup>
Others		

HBsAg  
Anti-HAV Igm

NOTE:

\_\_\_\_\_

*AK*

AIRA P. BALANSAG, RMT PRC#80834

Medical Technologist

*PK*  
PETER S. AZNAR, M.D., F.P.S.P.  
Pathologist  
PRC #72410



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DEPARTMENT OF HEALTH  
MORRIS GROUP POLYCLINICS AND DIAGNOSTIC CENTER, INC.  
2L APM CENTRALE MALL, SORIANO AVENUE, MABOLO, CEBU CITY, CEBU

Phone Number 266 3245

**DRUG TEST REPORT**

CCF No: 201903200002

Name: ALICO, JOHN PAUL LLAGA

Birthdate: 06/12/1993

Age: 25

Gender: M

Transaction Date Time: 3/25/2019 6:49:00AM

Report Date Time: 3/26/2019 5:22:59PM

**Test Method** TEST KIT

**Purpose**

Private Employment

**Requesting Parties**

IPLOY

**Result**

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

55 MS. AIMEN JOY GRONIFILLO AGURO

Analyst

Approved By

DR. PETER SANSON AZNAR

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Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

**PRIME CARE CEBU**





Prime CARE  
C E B U

**MEDGRUPPE POLYCLINICS AND DIAGNOSTIC CENTER, INC.**  
2<sup>ND</sup> Floor, APM Centrale Mall, Soriano Ave., NRA, Brgy. Mabolo, Cebu City, Philippines 6000  
Tel. No. (032) 232-2273 Fax: (032) 234-2273  
**CUSTODY AND CONTROL FORM**  
(Form DT-002A - COPY FOR THE DONOR)

SPECIMEN ID NO. 2893

LAB ACCESSION NO. 0320 0002

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

√ A. Client's/Donor's/Subject's Name	<u>ALICO, JOHN PAUL -</u>	√ B. Address:	<u>MINOBLANCA, CEBU</u>	C. Age:	<u>25</u>	√ D. Sex:	<u>M</u>
√ E. Employer Name and Address	<u>ACE TOWER, CEBU BUSINESS PARK</u>						
F. Type of Specimen:	G. Reason for Test:						
<input type="checkbox"/> Urine	<input type="checkbox"/> Pre-employment		<input type="checkbox"/> Random		<input type="checkbox"/> Reasonable Suspicion/Cause		
<input type="checkbox"/> Blood	<input type="checkbox"/> Return to Duty		<input type="checkbox"/> Mandatory		<input type="checkbox"/> Post Accident		
<input type="checkbox"/> Others(specify)	<input type="checkbox"/> Follow-up		<input type="checkbox"/> Others (specify)				
H. Drug Tests to be Performed:	<input checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP		<input checked="" type="checkbox"/> THC & MET Only		<input type="checkbox"/> Others (specify)		

STEP 2 COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 32°C and 38°C? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specimen Collection: Specimen Sampling: <u>u</u> ml. Physical Appearance: Color: _____ <input checked="" type="checkbox"/> Observed <input type="checkbox"/> Single <input type="checkbox"/> Unobserved <input type="checkbox"/> Split	Other Observation (Enter Remark)
REMARKS		

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initial seal(s). Donor completes STEP 5.

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Step 5 of this form was collected, sealed and released to the Delivery Service noted in accordance with applicable Department of Health requirements.

X _____ Signature of Collector <b>FRANCIS FRITZ C. GARCIA</b> (PRINT) Collector's Name (first, MI, Last)	Time of Collection <u>MAR 20 2019</u> Date (Mo/Day/Yr)	AM/PM	SPECIMEN BOTTLE(S) RELEASED TO: Name of Delivery Service Transferring Specimen to Lab.
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RECEIVED AT LAB: X _____ Signature of Accessioner <b>FRANCIS FRITZ C. GARCIA</b> (PRINT) Accessioner's Name (First, MI, Last)	Date (Mo/Day/Yr) <u>20 2019</u>	STATUS OF THE SPECIMEN (a) Seal Intact <input type="checkbox"/> Yes <input type="checkbox"/> No (b) Transport Device _____ (c) Description _____	SPECIMEN BOTTLE(S) RELEASED TO: Signature & Printed Name of Receiving Person Print Name (First, MI, Last) Date (Mo/Day/Yr)
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STEP 5 COMPLETED BY THE DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the affixed bottle is correct.

Signature of Donor <u>JOHN PAUL ALICO</u> (PRINT) Donor's Name (First, MI, Last)	√ Date of Birth <u>06 / 12 / 1993</u> Mo Day Yr
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Additional information may be asked from you by the laboratory particularly on drugs and medications.

STEP 6: COMPLETED BY HEAD OF SCREENING LABORATORY

In accordance with applicable Department of Health requirements, my determination/verification is:

NEGATIVE  POSITIVE  TEST CANCELLED  REFUSAL TO TEST BECAUSE:  
 DILUTED  ADULTERATED  SUBSTITUTED  
 OTHERS (Specify) 019

REMARKS \_\_\_\_\_

X _____ Signature & Name of Analyst (First, MI, Last) <b>AIMEN JOY G. AGURO, RMT</b>	Signature & Name of Head of Laboratory (First, MI, Last) <b>PETER S. AZNAR, M.D., F.P.S.P.</b>	Date (Mo/Day/Yr)
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STEP 7: COMPLETED BY CONFIRMATORY LABORATORY

In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:

CONFIRMED FOR:  CHALLENGE  FAILED TO CONFIRM - REASON \_\_\_\_\_  
 THC  MET  OTHERS \_\_\_\_\_

X _____ Signature of Analyst	(PRINT) Signature & Name of Head of Laboratory (First, MI, Last)	Date (Mo/Day/Yr)
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STEP 8: TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRL)

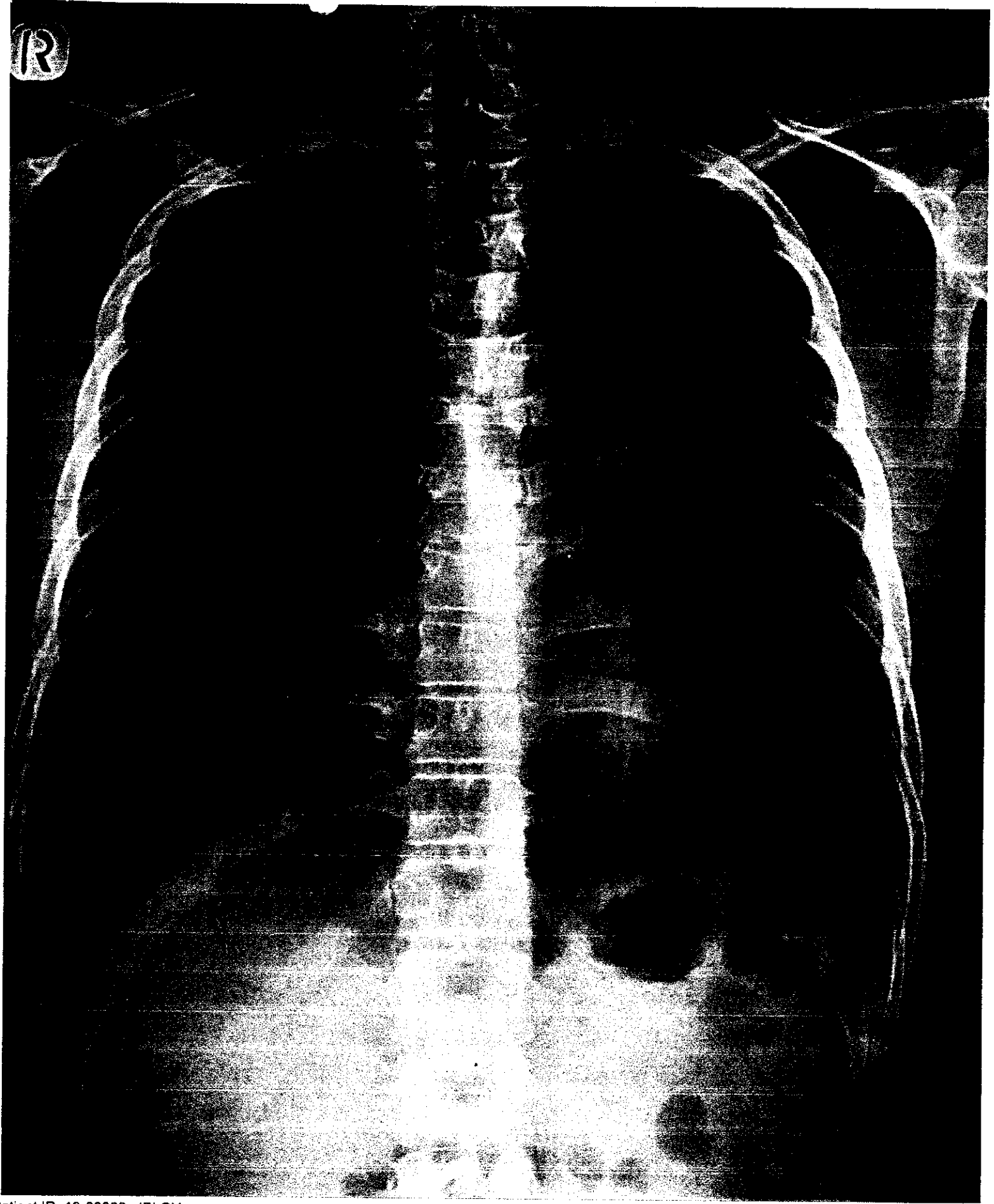
In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:

RECONFIRMED FOR:  THC  MET  FAILED TO CONFIRM - REASON \_\_\_\_\_  
 OTHERS \_\_\_\_\_

X _____ Signature of Analyst	(PRINT) Signature & Name of Head of Laboratory (First, MI, Last)	Date (Mo/Day/Yr)
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- Form DT - 002A - Copy for the Donor
- Form DT - 002B - Copy for the Collection Site
- Form DT - 002C - Copy for the Laboratory
- Form DT - 002D - Copy for the Confirmatory Laboratory (For Positive Sample)

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Patient ID: 19-06068 IPLOY  
Patient Name: ALICO,JOHN PAUL  
Study Date: 03/20/2019