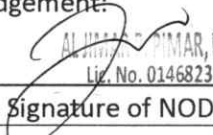



CLINIC SLIP

Employee Name: MELHORAE p. DANK		Date: 09/30/2019
Employee Number: 01196	Time In: 10:43 PM	Time Out:
Supervisor's Name and signature: <i>Kate Coballer</i>		
Complaint: PE Reevaluation		
Focused History and Physical Exam: @HIP @IM BP 120/80 ECG, CR, PHS, PFT, SPP, CRT C2M Fit to work - Class A		
Medication Given:		
RECOMMENDATION: <i>low</i>		
<input type="checkbox"/> Clinic Rest	Time/Duration:	
<input type="checkbox"/> Send Home	Inclusive Dates:	
<input type="checkbox"/> ER Conduction	Institution:	
Acknowledgement: <div style="display: flex; justify-content: space-between;"> <div style="text-align: center;">  ALVIN PINAR, MD Lic. No. 0146823 Name & Signature of NOD/Physician </div> <div style="text-align: center;">  Patient's Signature </div> </div>		

Annual Physical Examination []

Pre-Employment []

Last Name DAN First Name Muhammad M.I. P. Date 05-20-2019
MELHORNE
 Address MAHAJAHAY BANKAL LLC Age 22 yrs. old Civil Status SINGLE Sex M
 Place of Birth SABAH, MALAYSIA Date of Birth 02-24-1997 Insurance Provider _____
 Occupation CSR Name of Company IPUY Tel. / Mobile no. 0928747850

PHYSICAL EXAMINATION

Temp.: 36 °C PR: 88 bpm RR: 16 bpm BP: 120/80 mmHg Ht: 167 cm Wt: 59.5 kgs.
 Visual Acuity: Right Eye: 20/20 Left Eye: 20/20 BMI: 21.4 Underweight: Overweight:
 (With/ Without eyeglasses) Normal Weight: Obese:

MEDICAL HISTORY

Past Medical History: _____
 Family History: _____
 Previous Hospitalization: _____
 Menstrual History: _____ y.o 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:		
Urinalysis	<input checked="" type="checkbox"/>	<u>UTI</u>			
Fecalalysis					
Drug Test					

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
 CLASS C Physically fit for less strenuous type of work. Has minor ailments/ defects.
 CLASS D Employment at the risk and discretion of the management
 CLASS E Unfit for employment
 PENDING For further evaluation of: _____

M. H. PIMAR, MD
 Lic. No. 0146823

Remarks: _____
 Patient's Signature: _____ Date Examined: 5/21/19
 Medical Examiner: _____, M.D.
 License No.: _____

M. H. PIMAR, MD
 License No. 33180



Medgrupee Polyclinics & Diagnostic Center, Inc.

2nd Level, APMA Central, A. Soriano Jr. Ave., N.E.A. Marikina, Cebu City, 6000 Philippines
Tel Nos. (832) 232-2273 * (832) 266-3245

LABORATORY DEPARTMENT

License TO OPERATE No.: 07-055-17-AS-2

No.: 165656

SO No.: 00753829

Name: DANO, MELHORNE POLO

Age: 22 yrs.

Date: 05/20/2019

Requested by:

Company: IPLAY INC.,

Sex: MALE

Patient Status:

Change To: IPLAY INC.,

COMPLETE BLOOD COUNT

	Normal Values
() WBC	6,200 /mm ³ 5,000-10,000 /mm ³
() RBC	5.32 x 10 ⁶ /mm ³ Adult F: 4.2 - 5.4 X 10 ⁶ /mm ³ M: 4.7 - 6.10 X 10 ⁶ /mm ³ Pediatric F: 4.0 - 5.1 X 10 ⁶ /mm ³ M: 4.0 - 5.3 x 10 ⁶ /mm ³
() Hemoglobin	15.96 gm%
() Hematocrit	47.90 gm%
Differential Count	
Neutrophils	70 %
Lymphocytes	28 %
Monocytes	1 %
Eosinophils	1 %
Basophils	0-2%
Platelet Count	381,000 /mm ³ 150,000-450,000 /mm ³
Others	

HBSAg
Anti-HAV IgM

NOTE:

FLORA MAE B. GALAY, RMT
Medical Technologist

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



Medgrupee Polyclinics & Diagnostic Center, Inc.

2nd Level, APMA Central, A. Soriano Jr. Ave., N.E.A. Marikina, Cebu City, 6000 Philippines
Tel Nos. (832) 232-2273 * (832) 266-3245

LABORATORY DEPARTMENT

License TO OPERATE No.: 07-055-17-AS-2

No.: 163279

SO No.: 00753829

Name: DANO, MELHORNE POLO

Age: 22 yrs.

Date: 05/20/2019

Physician:

Company: IPLAY INC.,

Patient Status:

Change To: IPLAY INC.,

Sex: MALE

URINALYSIS

MACROSCOPIC:	
Color	Light Yellow
Appearance	Clear
pH	6.0
Specific Gravity	1.015
Glucose	Negative
Protein	Negative
MICROSCOPIC:	
RBC / hpf	0-1
WBC / hpf	3-5
Epith. Cells / hpf	Rare
Casts	
Mucous Threads	Rare
Bacteria	Rare
Cystals	
Amorphous (Urates)	Rare
Amorphous (PO ₄)	
MISCELLANEOUS:	
Pregnancy Test	N/A
OTHERS:	

NOTE:

ELISHA MAIRE G. BANAYAY, RMT
Medical Technologist

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



DEPARTMENT OF HEALTH
MELBORNE POLYCLINICS AND DIAGNOSTIC CENTER
2L APM CENTRALE MALL, SORIANO AVENUE, MABOLO, CEBU CITY, CEBU

Phone Number 266 3245

DRUG TEST REPORT

QJ912497
38

CCF No: 201905200004
Name: DANO, MELJHORNE POLO
Birthdate: 02/24/1997 Age: 22 Gender: M

Transaction Date Time: 5/22/2019 9:52:00AM
Report Date Time: 5/22/2019 5:37:39PM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY

Result

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

Approved By

44 MS. AIMEN JOY GRONIFILLO AGURO

DR. PETER SANSON AZNAR 94

Analyst

Head of Laboratory

Valid Within 12 Month/s from Transaction Date

This is a DOH-DDB IDTOMIS generated report

PRIME CARE CEBU



MEDGRUPPE POLYCLINICS AND DIAGNOSTIC CENTER, INC.
 2ND 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. 4935 LAB ACCESSION NO. 05200004

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

√ A. Client's/Donor's/Subject's Name DANO, MEJHORNE P. √ B. Address: LAPU-LAPU CITY √ C. Age: 22 √ D. Sex: M
 √ E. Employer Name and Address _____
 F. Type of Specimen: Urine Blood Others(specify) _____
 G. Reason for Test: Pre-employment Return to Duty Random Mandatory Follow-up Reasonable Suspicion/Cause Post Accident Others (specify) _____
 H. Drug Tests to be Performed: THC, COC, PCP, OPI, AMP THC & MET Only Others (specify) _____

STEP 2 COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 32°C and 38°C? Yes No
 Specimen Collection: Observed Unobserved
 Specimen Sampling: Single Split
 Specimen Volume: _____ ml. Physical Appearance: Color: Y
 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.
 Signature of Collector _____ AM/PM _____
 (PRINT) Collector's Name (first, MI, Last) _____ Date (Mo/Day/Yr) MAY 19 2019
 SPECIMEN BOTTLE(S) RELEASED TO: _____
 Name of Delivery Service Transferring Specimen to Lab. _____

RECEIVED AT LAB: Signature of Accessioner _____
 (PRINT) Accessioner's Name (First, MI, Last) _____ Date (Mo/Day/Yr) MAY 20 2019
 STATUS OF THE SPECIMEN: (a) Seal Intact Yes 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) _____

STEP 5 COMPLETED BY THE DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it 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 [Signature] (PRINT) Donor's Name (First, MI, Last) MEJHORNE P. DANO
 Contact No. 09287417850 √ Date of Birth 05/20/2019
 Mo Day Yr 02/24/1977
 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) _____
 REMARKS _____
 AIMEN JOY G. AGURO, RMT Signature & Name of Analyst (First, MI, Last) _____
 PETER S. AZNAR, M.D., F.P.S.P. Signature & Name of Head of Laboratory (First, MI, Last) _____
 Date (Mo/Day/Yr) MAY 20 2019

STEP 7: COMPLETED BY CONFIRMATORY LABORATORY

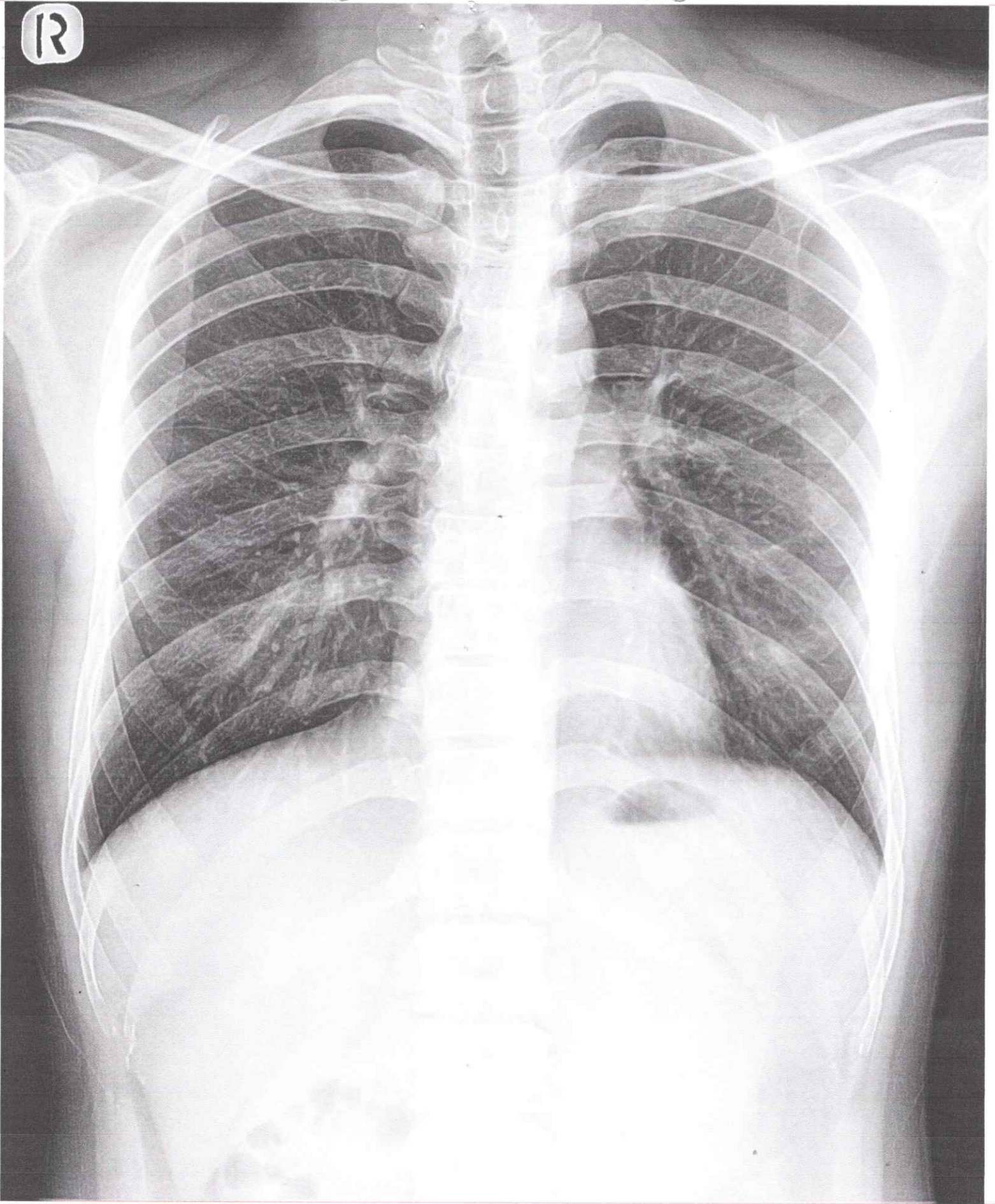
In accordance with applicable Department of Health requirements, my determination/verification for the specimen (if tested) is:
 CONFIRMED FOR: CHALLENGE FAILED TO CONFIRM - REASON _____
 THC MET OTHERS _____
 Signature of Analyst _____ (PRINT) Signature & Name of Head of Laboratory (First, MI, Last) _____
 Date (Mo/Day/Yr) _____

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: FAILED TO CONFIRM - REASON _____
 THC MET OTHERS _____
 Signature of Analyst _____ (PRINT) Signature & Name of Head of Laboratory (First, MI, Last) _____
 Date (Mo/Day/Yr) _____

1. Form DT - 002A - Copy for the Donor
2. Form DT - 002B - Copy for the Collection Site
3. Form DT - 002C - Copy for the Laboratory
4. Form DT - 002D - Copy for the Confirmatory Laboratory (for Positive Sample)

R



Patient ID: 19-09059 IPLOY INC
Patient Name: DANO, MELJHORNE
Study Date: 05/20/2019