

Annual Physical Examination []

Pre-Employment [✓]

Last Name Rosal First Name Alyssa M.I. A. Date May 18, 2019
 Address Bagakay, Sandayong Sur, Davao Age 21 Civil Status Single Sex Female
 Place of Birth Compostela City Date of Birth Dec. 8, 1997 Insurance Provider _____
 Occupation CSR Name of Company lplay Inc. Tel. / Mobile no. 09434209102

PHYSICAL EXAMINATION

Temp.: 35.7 °C PR: 82 bpm RR: 17 bpm BP: 110/80 mmHg Ht: 153 cm Wt: 41.2 kgs.
 Visual Acuity: Right Eye: 20/20 Left Eye: 20/20 BMI: 17.4 Underweight: Overweight:
 (With/ Without eyeglasses) Normal Weight: Obese:

MEDICAL HISTORY

Past Medical History: (L) BA
 Family History: None
 Previous Hospitalization: (-)
 Menstrual History: 12 y.o Parity: - LMP: 5/8/2019 Contraceptive Use: -
Regular - 5 to 7 days

Review of Systems	Normal	Findings	Review of Systems	Normal	Findings
Head & Scalp	/		Lungs	/	
Eyes & Ears	/		Heart	/	
Skin / Allergy	/		Abdomen	/	
Nose & Sinuses	/		Genitals	/	
Mouth (Teeth) / Tongue	/	<u>dental caries</u>	Extremities	/	
Neck / Nodes	/		Reflexes	/	
Chest/ Breast	/		BPE	/	

Laboratory	Normal	Findings	Laboratory	Normal	Findings
Chest X-Ray	/		ECG	/	
CBC	/		Other Procedures:	<u>NA</u>	
Urinalysis	/				
Fecalalysis	/				
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 Underweight, Dental caries
 [] 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 May 18, 2019 Merwin Romas, M.D.
 Medical Examiner
 License No.: 2214



Medgrupe Polyclinics & Diagnostic Center, Inc.

IMMEDIATE MEDICAL AND DENTAL CARE CENTER

2nd Level, AFM Centrale, A. Soriano Jr. Ave., N.R.A.
Mabala, Cebu City, 6000 Philippines
Tel Nos. (032) 232-2273 * (032) 266-3205

LABORATORY DEPARTMENT

License TO OPERATE No. : 07-066-17-AS-2

No.: 165676 SO No.: 00753807
 Name: ROSAL, ALYSSA ARENAS Age: 21 yrs. Date: 05/20/2019
 Requested by: _____ Sex: FEMALE
 Patient Status: _____ Company: IPLOY INC.,
 Charge To: IPLOY INC.,


COMPLETE BLOOD COUNT

			Normal Values
() WBC	<u>6,200</u>	/mm ³	5,000-10,000 /mm ³
() RBC	<u>4.24</u>	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
			Pedia F: 4.0 - 5.1 X 10 ⁶ /mm ³ M: 4.0 - 5.3 x 10 ⁶ /mm ³
() Hemoglobin	<u>12.73</u>	gm%	F: 12-15gm% M: 14-17gm%
() Hematocrit	<u>38.20</u>	gm%	F: 38-48vol% M: 40-50vol%
Differential Count			
Neutrophils	<u>66</u>	% *	45-65%
Lymphocytes	<u>28</u>	%	20-35%
Monocytes	<u>3</u>	%	2-9%
Eosinophils	<u>3</u>	%	0-6%
Basophils		% -	0-2%
Platelet Count	<u>249,000</u>	/mm ³	150,000-450,000 /mm ³
Others			

HBsAg _____
 Anti-HAV IgM _____

NOTE: _____


 RAIZA JEYD D. DELA CUESTA, RMT
 Medical Technologist


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



Medgrupe Polyclinics & Diagnostic Center, Inc.

IMMEDIATE MEDICAL AND DENTAL CARE CENTER 2nd Level, APM Centrale, A. Soriano Jr. Ave., N.R.A. Mabolo, Cebu City, 6000 Philippines
Tel Nos. (032) 232-2273 * (032) 266-3245

LABORATORY DEPARTMENT

License TO OPERATE No. : 07-065-17-AS-2

No.: 163298 SO No.: 00753807
Name: ROSAL, ALYSSA ARENAS Age: 21 yrs. Date: 05/20/2019
Physician: _____ Sex: FEMALE
Company: IPLOY INC., Patient Status: _____
Charge To: IPLOY INC.,

URINALYSIS

MACROSCOPIC:

Color	<u>Yellow</u>
Appearance	<u>Slightly Hazy</u>
pH	<u>6.5</u>
Specific Gravity	<u>1.010</u>
Glucose	<u>Negative</u>
Protein	<u>Negative</u>

MICROSCOPIC:

RBC / hpf	<u>0-1</u>
WBC / hpf	<u>0-2</u>
Epith. Cells / hpf	<u>Few</u>
Casts	_____
Mucus Threads	<u>Few</u>
Bacteria	<u>Rare</u>
Crystals	_____
Amorphous (Urates)	<u>Few</u>
Amorphous (PO ₄)	_____

MISCELLANEOUS:

Pregnancy Test	<u>N/A</u>
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OTHERS:

NOTE:

AIRA P. BALANSAG, RMT PRC#80634
Medical Technologist

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



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

Phone Number 266 3245

DRUG TEST REPORT

CCF No: 201905180037
Name: ROSAL, ALYSSA ARENAS
Birthdate: 12/08/1997 Age: 21 Gender: F

Transaction Date Time: 5/22/2019 9:49:00AM
Report Date Time: 5/22/2019 5:34:25PM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY

Result

Drug/Metabolite	Result	Remarks
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

Approved By

65 MS. AIMEN JOY GRONIFILLO AGURO

DR. PETER SANSON AZNAR

66

Analyst

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.
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. 4030

LAB ACCESSION NO. 05780037

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

✓ A. Client's/Donor's/Subject's Name <u>Alyssa Rosal</u>	✓ B. Address: <u>Ayala, cebu city</u>	✓ C. Age: <u>21</u>	✓ D. Sex: <u>F</u>
✓ E. Employer Name and Address <u>Ipoy, Inc. Ayala, cebu city</u>			
F. Type of Specimen: <input checked="" type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Others(specify) _____	G. Reason for Test: <input type="checkbox"/> Pre-employment <input type="checkbox"/> Return to Duty <input checked="" type="checkbox"/> Random <input type="checkbox"/> Mandatory <input type="checkbox"/> Follow-up <input type="checkbox"/> Others (specify) _____		
H. Drug Tests to be Performed: <input 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Specimen Collection: <input checked="" type="checkbox"/> Observed <input type="checkbox"/> Unobserved Specimen Sampling: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Split Specimen Volume: <u>2</u> ml. Physical Appearance: Color: <u>Y</u>	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 <u>MILYN FLORES</u> (PRINT) Collector's Name (First, MI, Last)	AM/PM Time of Collection <u>MAY 18 2019</u> Date (Mo/Day/Yr)	SPECIMEN BOTTLE(S) RELEASED TO: Name of Delivery Service Transferring Specimen to Lab.
RECEIVED AT LAB: X Signature of Accessioner <u>MILYN FLORES</u> (PRINT) Accessioner's Name (First, MI, Last)	STATUS OF THE SPECIMEN (a) Seal Intact <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (b) Transport Device _____ (c) Description _____ Date (Mo/Day/Yr) <u>MAY 18 2019</u>	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 <u>Alyssa Rosal</u> (PRINT) Donor's Name (First, MI, Last)	✓ Date of Birth <u>5 / 18 / 1997</u> Mo Day Yr
✓ Contact No. <u>09434209102</u>	

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 Free

X Signature & Name of Analyst (First, MI, Last) <u>AIMEN JOY G. AGUERO, RMT</u>	Signature & Name of Head of Laboratory (First, MI, Last) <u>PETER S. AZNAR, M.D., F.P.S.P.</u>	Date (Mo/Day/Yr) <u>MAY 18 2019</u>
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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: THC MET CHALLENGE 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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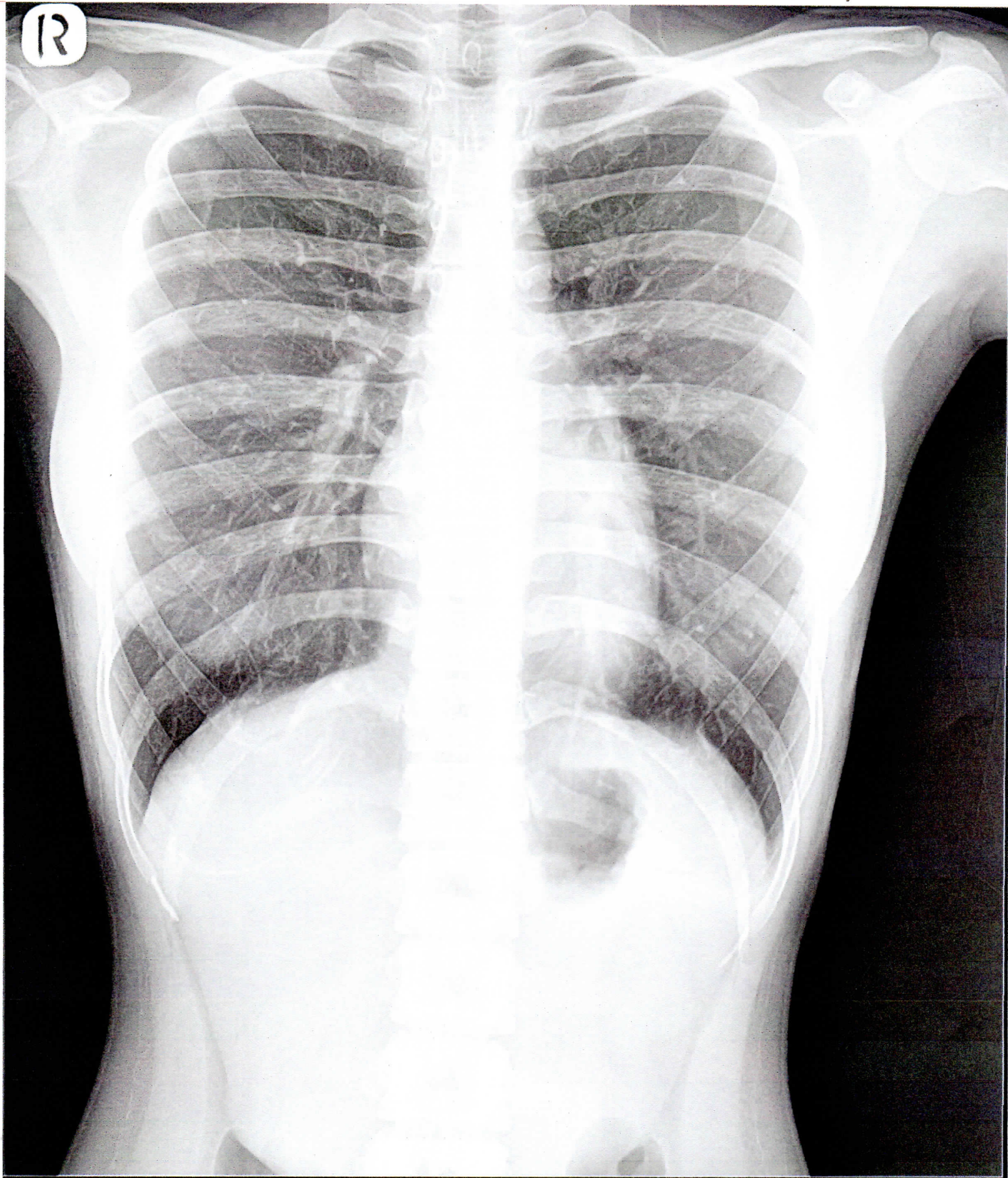
STEP 8: TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRL)

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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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)



Patient ID: 19-09052 IPLOY
Patient Name: ROSAL,ALYSSA
Study Date: 05/18/2019