Prime Care CEBU

IMMEDIATE MEDICAL & DENTAL CARE CENTER

MEDICAL EXAMINATION RECORD

Annual Physical Examination [ ] Pre-Employment [ ]

Last Name ABAPO **First Name** [illegible] **M.I.** D **Date** 6/18/[illegible]

Address [illegible] **Age** [illegible] **Civil Status** SINGLE **Sex** M

Place of Birth [illegible] **Date of Birth** [illegible] **Insurance Provider**

Occupation CSR **Name of Company** [illegible] **Tel. / Mobile no.** 09955 [illegible]

PHYSICAL EXAMINATION

Temp.: 35.9 °C PR: 82 bpm RR: 15 bpm BP: 110/80 mmHg Ht: 160 cm Wt: 75 kgs.

Visual Acuity: Right Eye: 20/ 25 Left Eye: 20/ 25 BMI: 29.2 Underweight: [ ] Overweight: [✓]

(With/ Without eyeglasses) Normal Weight: [ ] Obese: [ ]

MEDICAL HISTORY

Past Medical History: (-)

Family History: HPN

Previous Hospitalization: (-)

Menstrual History: ______ y.o Parity: ______ LMP: ______ Contraceptive Use: ______

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	✓		Extremities	✓	
Neck / Nodes	✓		Reflexes		
Chest/ Breast	✓		BPE		

Laboratory	Normal	Findings	Laboratory	Normal	Findings
Chest X-Ray	✓		ECG		
CBC	✓		Other Procedures:	ND	
Urinalysis	✓				
Fecalysis					
Drug Test	NA				

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

[illegible signature], M.D.
Medical Examiner

License No.: [illegible]

Medgruppe 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.: 165053 SO No.: 00758071

Name : ABAPO, ED STRUCT DAYDAY Age : 24 yrs. Date: 6/18/2019

Physician : Sex : MALE

Company : IPLOY INC., Patient Status:

Charge To: IPLOY INC.,

URINALYSIS

MACROSCOPIC:

Color	Light Yellow
Appearance	Clear
pH	6.5
Specific Gravity	1.010
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_4)	

MISCELLANEOUS:

Pregnancy Test N/A

OTHERS:

NOTE:

ELISHA MARIE G. BANAAY, RMT
Medical Technologist

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

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Tel Nos. (032) 232-2273 * (032) 266-3245

LABORATORY DEPARTMENT

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

No.: 167478 SO No.: 00758071

Name: ABAPO, ED STRUCT DAYDAY Age: 24 yrs. Date: 6/18/2019

Requested by: Sex: MALE

Patient Status: Company: IPLOY INC.,

Charge To: IPLOY INC.,

COMPLETE BLOOD COUNT

				Normal Values
( ) WBC	8,600	/mm^3		5,000-10,000 /mm^3
( ) RBC	5.03	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	15.10	gm%		F: 12-15gm% M: 14-17gm%
( ) Hematocrit	45.30	gm%		F: 38-48vol% M: 40-50vol%
Differential Count				
Neutrophils	55	%		45-65%
Lymphocytes	38	%	*	20-35%
Monocytes	5	%		2-9%
Eosinophils	2	%		0-6%
Basophils		%	--	0-2%
Platelet Count	338,000	/mm^3		150,000-450,000 /mm^3
Others				

HBsAg

Anti-HAV IgM

NOTE:

LOVELY DEIGNS R. GLORI, RMT PRC#009
Medical Technologist

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

VT

Report ID: DTO-R03

QL981394
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DEPARTMENT OF HEALTH
MEDGRUP[illegible] POLYCLINICS AND DIAGNOSTIC CENTER, INC.
2L APM CENTRAL[illegible]ALL, SORIANO AVENUE, MABOLO, CEBU CITY, C[illegible]
Phone Number 266 3245

DRUG TEST REPORT

CCF No: 201906180001
Name: ABAPO, ED STRUCT DAYDAY
Birthdate: 09/13/1994 Age: 24 Gender: M

Transaction Date Time: 6/18/2019 8:36:00AM
Report Date Time: 6/18/2019 5:55:35PM

Test Method TEST KIT

Purpose
Private Employment

Requesting Parties
IPLOY

Result

Drug/Metabolite	*Result*	*Remarks*
METHAMPHETAMINE	NEGATIVE	
TETRAHYDROCANNABINOL	NEGATIVE	

Test Conducted By

65 MS. AIMEN JOY GRONIFILLO AGURO
Analyst

Approved By

DR. PETER SANSON AZNAR 96
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 L U B

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. Urine LAB ACCESSION NO. 06180001

STEP 1 COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

√ A. Client's/Donor's/Subject's Name ED STRUCT ABAPO √ B. Address: TISA, CEBU CITY √ C. Age: 24 √ D. Sex: M
√ E. Employer Name and Address PLDT AYALA CENTER CEBU
F. Type of Specimen:
/ / Urine
/ / Blood
/ / Others(specify) _____
G. Reason for Test :
/ / Pre-employment / / Random / / Reasonable Suspicion/Cause
/ / Return to Duty / / Mandatory / / Post Accident
/ / Follow-up / / 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: 45 ml. Physical Appearance: Color: Yellow

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
_____ AM/PM Time of Collection
[redacted] (PRINT) Collector's Name (First, MI, Last)
JUN 18 2019 Date (Mo/Day/Yr)

SPECIMEN BOTTLE(S) RELEASED TO:
_____ Name of Delivery Service Transferring Specimen to Lab.

RECEIVED AT LAB:
X _____ Signature of Accessioner
[redacted] (PRINT) Accessioner's Name (First, MI, Last)
JUN 18 2019 Date (Mo/Day/Yr)

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
√ ED STRUCT D. ABAPO (PRINT) Donor's Name (First, MI, Last)
√ 6/18/19 Date (Mo/Day/Yr)
√ Contact No. 09955228491
√ Date of Birth 09/13/1994 Mo Day Yr

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 _____

X 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)
JUN 18 2019 Date (Mo/Day/Yr)

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)

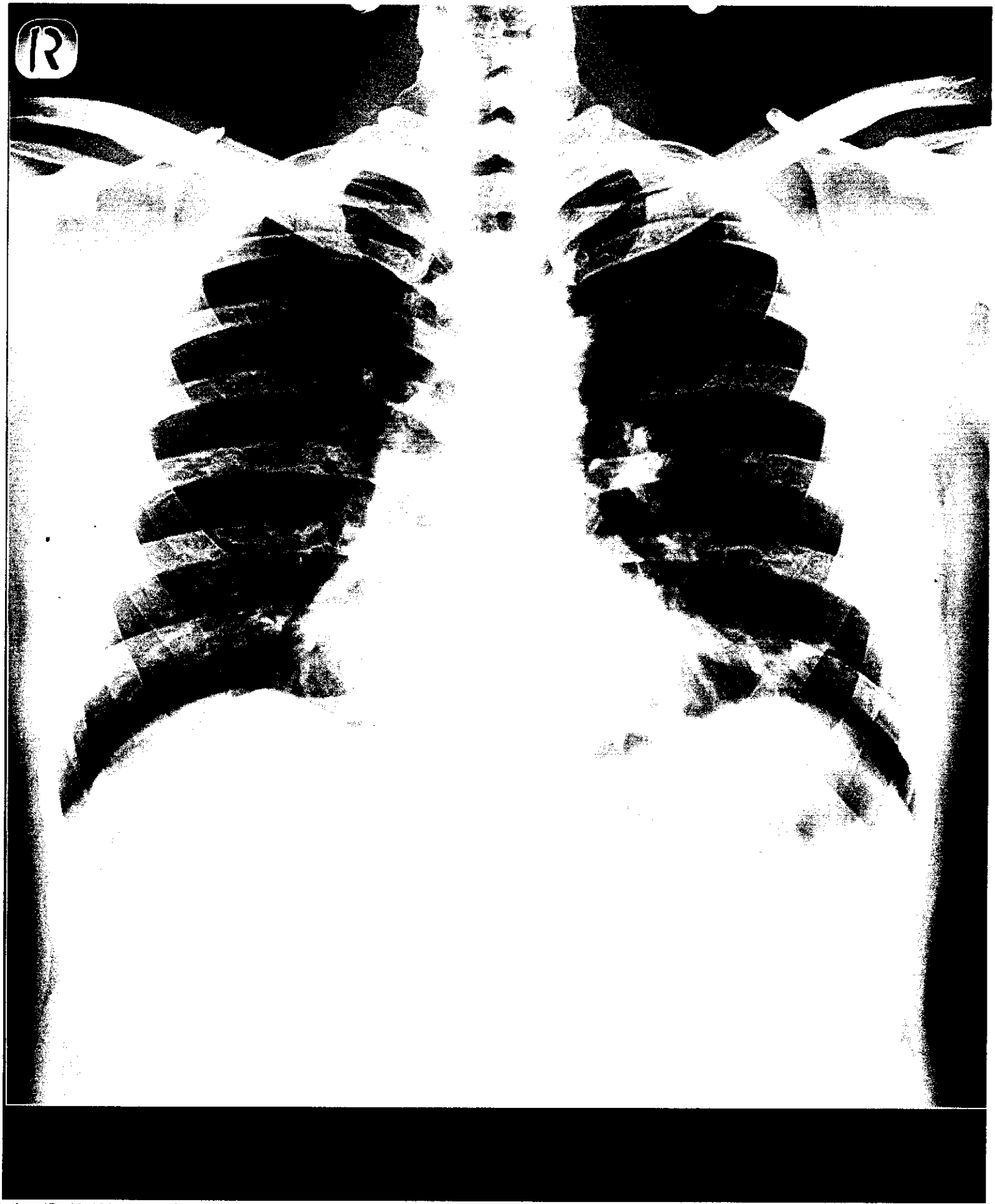
☐ STEP 8 : *TO BE COMPLETED BY NATIONAL REFERENCE LABORATORY (NRL*

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)

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 (Positive Sample)



Patient ID: 19-10855 IPLOY
Patient Name: ABAPO,ED STRUCT D
Study Date: 06/18/2019